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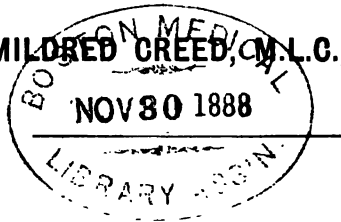
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The Honorable JOHN MILNOR CREED, M.L.C., L.R.C.P., M.R.C.S.E., &c.



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AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES. NOV 30 1888

**NOTES ON A CASE OF LANDRY'S
PARALYSIS: (PARALYSIS ACUTA
DENS ACUTA).—RECOVERY.**

(READ BEFORE THE N. S. W. BRANCH, B.M.A.)

By A. JARVIS HOOD, M.B., ET CH. M. GLASGOW,
MACLEAN, CLARENCE RIVER, N.S.W.

It is with some diffidence that I venture to commit myself to a diagnosis in this case, of which I am about to submit notes for your consideration, but, after the second time I came in contact with it, the symptoms seemed to me unequivocal, and I trust that, after hearing the notes read, you will at least grant that I had some reason for the faith that was in me.

On Feb. 2, of this year, the subject of these notes, A. F., a girl *æt.* 9, was brought to my consulting room. I was struck with her appearance on entering. Her father had carried her to the verandah, but she wanted to walk in herself; when she did so she dragged one leg after the other, and looked as if she would fall forward; her eyes were widely dilated, her cheeks slightly flushed, and her face wore an anxious expression. Her father stated that she was suffering from "pains in her legs," but on closely questioning her, I found that the pains he referred to were simply a wearied feeling in the muscles, especially after trying to walk. She was a very intelligent child, and answered my questions readily and clearly. On asking her to walk across the room, she did so very slowly and circumspectly, and rested more on the fore part of the foot than on the heel; there was no loss of equilibrium, but she turned very carefully. Examination of the lower limbs showed no wasting of the muscles, no loss of sensation, and no "reaction of degeneration"; the patellar tendon reflex was normal in both legs. She had come some distance in a small boat, and was so tired that further examination was out of the question, so she was sent to lodgings in town.

The following was all the history obtainable from the father: up till two days before I saw her she had been apparently in her usual state of health, not very robust at the best, with the exception of some loss of appetite, which had been noticed for a few weeks. About a fortnight, however, before this illness commenced, the Clarence district was visited by a heavy flood, and the house in which the child was living

was completely surrounded by water for about a week. She had been continually getting into the water and getting her clothes wet, and might have been going about for hours on several occasions with her wet clothes on before being noticed, and dry clothes substituted. After the water subsided, a thick deposit of mud, dead fish, and decaying vegetable matter was left on the ground, and for at least a fortnight the emanations from it were offensive in the extreme, probably accounting for the prevalence of a severe form of diarrhoea at that time. Her first complaint, viz., on January 31, was that she could not walk, but her friends, thinking that she was malingering to escape school, took no notice of it. The next day, however, they saw that she did not attempt to walk about, and the third day they brought her up to me.

I called and saw her the same evening again, temperature was 101.6° F.; pulse, 120, and soft. Respirations, 30 per minute, and very shallow. The tongue was coated, the bowels had not moved for two days, and the pupils were normal. She could move her body about in bed quite freely, except in so far as the loss of power in the legs prevented her, and she had complete use of her arms; there was no difficulty in swallowing, and altogether she was much happier in bed; the urine was passed freely, and was quite normal on examination. A powder containing 8 grs. calomel, and 15 grs. pulv. jalap co. administered.

Feb. 3.—When I saw her this morning, I found she had passed a restless night; the bowels had moved, but not very freely; temperature was 100.2° F.; pulse, 120; respirations, 30. She had some difficulty in moving in bed, and had completely lost the power of her legs, but there was no loss of sensation, and no difference in electrical tests. There was no loss of power in upper extremities, but paresis of the muscles of the trunk and back was very marked, as she was unable to sit up in bed without assistance, although when once up she could remain sitting without help. I had till then some doubt as to the diagnosis of the case, but now considered it one of acute ascending paralysis; consequently I prescribed *m* v doses of extract ergot liq., and *m* iij doses of tinct. belladonnæ every 4 hours. The diet was to consist of milk, soups, and beef-tea in small quantities, and given at short intervals. In the evening of the same day I again saw her, when the temperature was 100° F., pulse, 100, and respirations, 30, and very shallow; the bowels had not moved since the powder acted.

Feb. 4.—The muscles of the trunk were com-

pletely paralysed, and she was quite unable to move in bed. When lifted up to a sitting posture she fell back unless supported; the muscles of the neck were also distinctly affected, as she had some difficulty in balancing her head when sitting in bed supported. Temperature 99.6° F. a.m., 100° F. p.m.; respirations 28 and still very shallow; bowels still constipated, so ordered 3 ij of castor oil. In other respects treatment remained unaltered.

Feb. 5.—Muscles of neck quite paralysed, and she was unable to support the head, even when assisted to raise the head to the erect posture; if the head be allowed to fall backward she is unable, even by a supreme act of will, to raise it, and the same obtains when the head is allowed to fall forward with chin resting on sternum. To-day for the first time, she had some difficulty in swallowing, and some fluid she tried to swallow escaped by the nose, only however, in a slight proportion. The breathing was very shallow, and the voice markedly weak. She also complained of some weakness in the hands and arms, but there was no paresis discernible, as she could squeeze one's hand quite as strongly as one might expect in a healthy child of her age; still no defect in electrical reactions. Temperature, morning and evening, was 99.4° F; pulse, 112, very soft; respirations, 24.

Feb. 5.—The only difference noted was some paresis of hands and arms—and this was quite distinct; the difficulty in swallowing was still marked, but she clearly stated that it was not more so than on the day previous. The state of matters was then as follows:—Complete paralysis of the muscles of lower extremities, muscles of the trunk, and muscles of the neck. Some paresis of the muscles of deglutition and of respiration, and marked paresis of the muscles of the upper extremities; extreme constipation, induced probably by the paralysis of the abdominal muscles, but no implication of the bladder; temperature 99.4° F. I should have stated before that the intellect was intact. The appetite was good, and in addition to the diet before mentioned, she was allowed an egg beaten up with milk, a teaspoonful of brandy, and a little sugar to sweeten.

Feb. 7.—Condition was much the same as noted the day before, except that the paresis of hands and arms was, to a slight extent, more marked; still the same difficulty in swallowing, and the breathing was quick and shallow; but there was no cyanosis; constipation still severe, and ordered grs. xx pulv. jalap co. Sensibility was still unaffected, and the patellar tendon reflex normal; temperature 99.2° F. morning, and 99° F. in evening. Intelligence still intact, but the child wore an anxious expression; she complained

of no pain, but had a great feeling of weariness; pulse, 118; respirations, 22.

Feb. 8.—No change to note from day before, in any way, patient being certainly no worse; temperature 99° F. a.m., 99.2° F. p.m. The difficulty in swallowing and breathing same as before, and bowels again bound, so the castor oil was again administered. From this date to the 11th hardly any change was noticeable, but on the 12th she had more power in the hands and arms, and the difficulty in swallowing and breathing was much less. On the 13th she could swallow fairly well, and the dyspnoea was almost gone; she could lift her hands and arms, and could also move the toes, and the legs below the knees. She could also move her body a little in bed, and when held up, if the head were lifted she could keep it erect for about a minute, when it would either fall backward or forward according as the body inclined backward or forward. From this time forward she gradually improved, the improvement progressing from upper limbs, muscles of deglutition and respiration, neck, trunk and lower limbs, viz., in the inverse order to that in which the paresis made its appearance.

On the 16th Feb. she could use her hands and arms very well, had no difficulty in swallowing or breathing, was able to keep her head erect for some time, till a feeling of weariness overcame her and she desired to rest it on the pillow; she was able to move in bed, but not able to sit up or stand. These latter she was able to do a few days afterwards, for a very short period. Daily she gained strength, and was able to go home on the 20th, and on that day, for the first time, she could walk a few steps with assistance, but she dragged one foot after the other, and had some difficulty in balancing herself; there was hardly any emaciation, or atrophy of the muscles to be noted. All through there was no difference in the electrical reactions, no decrease or increase in sensibility, and no alteration in the reflexes.

The treatment adopted was as indicated before, viz., ergot and belladonna, till the 16th, when they were stopped, and no medicine given till she left for home on the 20th, when she was ordered Parrish's syrup of the phosphates of iron, lime and soda, and this was kept on for nearly eight weeks. Massage was also commenced on the 20th, and kept up till I saw her for the last time on April 6, when it was discontinued, and she was sent to the coast, where she now is, and where she gets a bath every day, the whole body being rubbed down with salt water, and then scrubbed with a rough towel. When I saw her on April 6, she was to all appearance in perfect health, only she looked slightly thinner, but not a vestige

of the disease was present. There was no wasting of the muscles, nor any loss of power remaining; the electrical reactions were still perfect.

Remarks.—First, as to the diagnosis: I must grant that when I saw her first on the evening of Feb. 2, I was puzzled as to the exact nature of the case, but fully recognised that it was some form of spinal paralysis, and when I saw her next day, the extension of the paresis to the muscles of the trunk, and the complete paralysis of the lower limbs, were so suggestive of ascending paralysis of an acute nature that I perforce diagnosed Landry's paralysis. The fact of the progressive nature of the disease, the absence of the "reaction of degeneration," and later on the absence of rapid atrophy of the muscles, excluded poliomyelitis anterior acuta. Acute ascending myelitis was excluded on the ground of absence of sensory derangements, there being no trophic alterations in the skin, and the bladder and bowels being undisturbed in their functions except as regards a slight constipation. In several points it resembled Duchenne's paralysis (poliomyelitis anterior subacuta), viz., in its mode of onset, progressive slight fever, and absence of cerebral symptoms, also absence of bladder symptoms; but the absence of rapid atrophy of the muscles, of the "reaction of degeneration," and the intact state of the reflexes, distinguished it from that affection. Secondly as to the etiology: This was of course obscure, but my impression was that the exposure to wet and cold, and the wearing of wet clothes for a few days perhaps, followed by exposure to poisonous emanations from the deposit of decaying fish and other organic matter left by the flood, were sufficient to cause one at least to blame them as a probable cause of the attack; her not being in a robust state of health previously, may of course have had some predisposing influence. Thirdly: The treatment adopted was, I grant, to a great extent empirical, but was founded on the supposition that it was due to some inflammatory condition of the spinal cord, or of the anterior or motor roots of the spinal nerves, and in some manner analogous to infantile paralysis in its morbid anatomy. The rationale was to diminish the blood supply to the spine in the progressive or active stage, and later on to prevent atrophy and supply tone to the affected muscles.

The result was eminently satisfactory, but I do not presume to claim recovery on account of the course of treatment adopted, but simply wish to bring before the profession an example of a disease (if my diagnosis be correct) which is still shrouded in mystery, and which was fortunately seen, and mayhap appreciated, at an early stage of its existence.

A CASE OF HYDATID.

TREATED AT PARRAMATTA (N. S. WALES) DISTRICT HOSPITAL, BY WALTER BROWN, M.D., &c.

Mrs. K., aged 24 years, came to me in April last, suffering from what appeared to be an hydatid cyst. She stated that about five years ago she observed a small swelling under the border of the left ribs, to the front, and about three inches to the left of median line. Since then the tumour has slowly increased, and she has married and had children. Her general health has been good on the whole. The swelling gradually increased, and spread across the median line of the abdomen and as low as three inches below the umbilicus, and backwards on the left as far as the left kidney. The first sound of the heart was rough, without a distinct bruit. She was a good deal emaciated. Pulse weak; percussion clear about lower part of chest; could not detect any movement of tumour on full inspiration. There was some bending outwards of the cartilages of the ribs on the left. Her girth was 37 inches above the navel. I advised her to come into the District Hospital, which, through domestic trouble, she was unable to do until June 16.

The operation was undertaken on the 19th, and was commenced by making an incision two inches long through the skin between umbilicus and sternum, as nearly as I could judge over the attachment of the hydatid, and near the place where the swelling first commenced. A large curved aspirator needle was then introduced at the lower end of the incision, and a portion of the fluid drawn off. The point of the needle was then brought out at the upper end of the incision, holding the cyst wall between it and the parietes. The incision was then carried down to the cyst, held by the curved needle, which was seized and opened and secured by silver sutures to the abdominal parietes. About 14 pints of fluid escaped at this time. A piece of $\frac{1}{4}$ -inch gutta percha tubing was then introduced, and the patient returned to bed. She bore the chloroform and the operation very well. The gradual manner in which the fluid was first drawn off reduced the risk of syncope very much.

She had an opiate at 5 p.m. At 8 p.m. she complained of thirst and faintness, and a feeling of sickness when moving the body, but subsequently had a good night, and took nourishment at intervals.

20th.—Patient comfortable in forenoon, but about midday her temperature rose to 103, and in the afternoon she was much flushed. She was sponged with tepid water and had wet compress applied, and took Cal. and Op. powder, and in a

few hours was much better, and took liquid nourishment in small quantities. The temperature reached 104 about midnight, but soon fell to 102, and by morning it was only 100·8.

21st.—Through the day the temperature ranged between 100·8 and 98·4.

22nd.—Became hot and restless, and was unable to sleep, but slowly became cooler. Complained of flatulence and thirst, but temperature kept from 99 to 101·4.

23rd.—Cyst injected with weak solution of Condy's fluid once.

25th.—The same yesterday and to-day. Gutta percha tube removed and glass one substituted.

26th.—Sutures removed, as the cyst was drawing away from the wound. I had a glass drainage tube made $3\frac{1}{4}$ -in. long and curved, with three openings on each side besides the terminal one, and this was kept in from this time, being daily removed to be cleaned. About the twelfth day a portion of the pseudo-cyst came away with the tube, and afterwards at various intervals other portions, having the appearance of dirty white kid, of various thicknesses came away, accompanied by a profuse muco-purulent discharge. Latterly these pieces came away at intervals of about a week; and lastly (August 7) the hydatid cyst itself, with its characteristic white-of-egg appearance, and having a cystic form, came away.

The tube was kept in for another week at night only, and she was able to sit up for a few hours in the day. She gradually improved in flesh and strength, and on August 14th I left out the tube altogether, though there was some muco-purulent discharge still. The temperature has been normal for weeks. The fluid drawn off at the operation showed only a slight trace of albumen, and I could not detect any hooklets, but I found some after a few days in what came from the cyst through the drainage tube. From the nature of the cyst, from the absence of any tenderness or inequality over the liver, I think the hydatid must have attached itself to the peritoneum, behind the left lobe of the liver.

I daresay it will strike anyone as strange that the profuse muco-purulent discharge did not pass into the peritoneal cavity when the pseudo-cyst drew away from the sutures. The only explanation I can think of is that the drainage-tube produced adhesive inflammation round it, and so made a canal for itself, as the discharge flowed freely through the tube as well as by the side of it, and there was no tenderness below the incision or any other sign of peritonitis, and latterly no increase of temperature above normal. The only other application was carbolic oil (1 in 40), which was frequently poured into the tube.

August 25.—Very slight muco-purulent dis-

charge. Returned home. The state of her general health had greatly improved—in fact, she was better than she had been for five years.

One point of practical importance is the spot where the opening was made, as there is more probability of adhesion having taken place to the parietes over the spot where the swelling was first observed than in any other spot, from its longer contact with the parietes, as well as from its comparative immobility. If the cyst had been opened anywhere else it would at once have retracted, and some of the contents would have passed into the peritoneal cavity.

TWO CASES OF SUPRA-PUBIC LITHOTOMY.

By STEPHEN FLOOD, M.D., F.R.C.S.I., SURG. SUPT., AND ERNEST SHEAF, M.R.C.P., F.R.C.S. ED., HON. SURG., TOOWOOMBA HOSPITAL, QUEENSLAND.

H. H., aged 24 years, was admitted June 22, 1887, suffering from stone in the bladder, from symptoms of which he had suffered several years. June 24, Bigelow's crushing instrument was introduced into the bladder and the stone with some difficulty seized; it was considered too large and too hard for crushing and the attempt abandoned. The next day, under ether, the usual supra-pubic incision was made, the bladder recognized by depressing the handle of the catheter, which had been introduced into it. This organ was carefully raised in the upper and inferior angle of the wound by two silk sutures inserted by needles for the purpose and then incised with a bistoury. Lithotomy forceps and the index finger of the left hand were introduced into the bladder and the stone, with some stretching of the wound in the bladder, extracted. The stone was found to measure $2\frac{1}{4}$ inches in its longest diameter, and to weigh 850 grains.

The bladder was stitched up with fine catgut, but owing to the lacerated and uneven nature of the wound it was difficult to avoid including portions of the mucous coat. This may have accounted for the subsequent giving way of the stitches and extravasation of urine, which took place on the 28th, *i.e.*, three days after operation. The wound was lightly dressed with iodoform dressing and a broad bandage. Patient suffered no ill effects from ether till the 27th, when he vomited dark coloured vomit, which continued for two days. He suffered much from shock, pain and general depression and restlessness; a good

deal of the edges of the wound in the abdominal wall sloughed owing to extravasation and most of the urine came through the wound. Charcoal poultices were used until the slough separated. Salicylic acid sprinkled amongst tenax was found useful in counteracting the bad odour. No urine escaped from the wound from the 30th June till July 19, when a large quantity was passed. The wound granulating and looking healthy. Sulphate of copper was used to touch granulations and a probe, armed with nitrate of silver was introduced from time to time into a small sinus which communicated with the bladder. After August 15 no urine passed through the wound. On the 22nd he was discharged convalescent.

Case No. 2. B. L., aged 40, admitted August 2, suffered from symptoms of stone for 8 months. A stone was crushed for him by Dr. Beaufleur, Royal Adelphi Hospital, Manchester. August 6, on examination with the sound the stone was judged to be not larger than a marble, but owing to the presence of false passages and stricture of urethra the idea of crushing again was abandoned. The supra-pubic operation was performed in precisely the same manner as in case 1, only a small clear incision was made into the bladder and this very carefully closed with fine catgut (Glover's stitch), the muscular walls only of the bladder being included. A stone about the size and shape of a marble was extracted by the fingers, weighing 48½ grains. Dressed with iodoform gauze and salicylic wool.

On the third day after operation the drainage tube was removed, no sign of discharge.

On the 5th day three stitches (out of six) in the external wound were removed; on the 7th day the others were removed and adhesive plaster strapped over the wound. On that night there was a considerable rise of temperature, owing, perhaps, to a dose of aperient medicine which operated freely.

11th day. Patient up for a few hours; no rise of temperature; wound healthy.

13th. Complained of pain in passing urine, and frequent desire to pass it. Ordered Buchu and Pot. bicarb.

16th day. These symptoms disappeared and patient was allowed to get out of bed. He was allowed to dress himself daily.

On the 25th a small sinus became apparent, through which a little urine passed and continues to pass at this date (August 29.)

Remarks.—The points which seem most striking about these cases, in distinction from the usual lateral lithotomy, are, the very trifling hæmorrhage, the non-interference with the vasa seminalia in young men, and the greater ease in the performance.

CASE OF HÆMOPTYSIS— RECOVERY.

By H. V. DREW, M.R.C.S., RESIDENT SURGEON,
TIMARU HOSPITAL, CANTERBURY, NEW ZEALAND.

C., æt. 30, stoker, had suffered from previous attacks of hæmoptysis, and was sent to hospital having lost a large quantity of blood. He is a strongly built man, and says he can lift 5 cwt. when well.

On examining his chest I found some flattening on the left side, percussion note normal, the breathing a little harsh, and a few coarse crepitant râles—but really nothing to give rise to immediate apprehension.

I ordered ol. turpentine. Next day I was called in a hurry and found him bringing up blood in large quantities, and about half-a-chamberful in front of him. I gave a 20 m. dose of turpentine and it ceased. I now sent for some ergotine and put it ready in a hypodermic needle—3 grs. for a dose—and procured some ice; but notwithstanding every effort, and finally 3 grs. of ergotine every 4 hours, he continued to be subject to one great gush of blood once at least in the 24 hours for over a week. On the sixth day I was called at about 3 p.m. on account of bleeding, and gave ergotine subcutaneously at once. The bleeding ceased, but patient got a bluish colour (he was extremely weak at this time), broke out in a tremendous sweat, the pulse failed, and I thought he was dying and gave one ounce of brandy; this caused him to rally a little, but he was too weak to speak, and I continued giving it every 10 minutes in small quantities. Soon after this I "witnessed" a will drawn up by the Ven. Archdeacon Harper, for we certainly thought he could not live many hours.

At his own request I now gave him alum, having tried everything without much success, and whether because he was so weakened, or whether the alum was the cause I do not know, but there was no bleeding next day; but on the day after, the last day of the bleeding, he coughed violently, and brought up, besides a lot of blood and great masses of tubercle, a piece of lung tissue, jagged and eroded, floating in water, and about as much as would fill a good sized walnut shell.

Patient continued to cough up pieces of tubercle and blood-coloured sputa for a few days, and the latter was soon replaced by yellow nummulated masses. These have become less, and now he is scarcely spitting at all, has no pain in chest, and scarcely any sign of past illness, no night sweats, normal temperature, no cough to speak of, and

very little loss of flesh considering what he has gone through. He is now taking iron and quinine, and in a few days will leave the hospital.

He was only feverish for five days, and the highest temperature was 101° .

NOTE.—The above report was written nearly a year ago. He called at the hospital last week in perfect health, and has suffered no relapse.

March 27, 1887.

ANEURISM OF LEFT MIDDLE CEREBRAL ARTERY—RUPTURE INTO THE VENTRICLES—COMA WITH GENERAL TONIC SPASM—DEATH.

BY J. C. VERCO, M.D., LOND.; HON. PHYSICIAN, ADELAIDE HOSPITAL; LECTURER ON MEDICINE, ADELAIDE UNIVERSITY.

Mrs. C—, *æt.* 60. I was called to see her at half-past one in the afternoon of April 19, 1887, in a fit. She was lying on the floor of her kitchen, where she was said to have been found about twenty minutes before, with a pair of tongs and an upset chair atop of her. She was on her back, with the head arched rigidly backwards, the arms at a little distance from the sides, and the legs slightly separated. The arms were rigid at the shoulders, in slight abduction; at the elbows in complete extension; at the wrists in full pronation, and with the fingers and thumbs in half-flexion. The legs slightly abducted, extended at the hips, at the knees, at the ankles, and slightly turned inwards. On lifting them they remained stiff, but did not keep themselves up in the air. There was not a trace of plantar reflex. The lower jaw was rigidly closed; the eyes were wide open, though not extremely so; pupils small, but not extremely so; the right one, apparently from old iritis, had its long diameter transverse, being of an oval shape. There was almost complete conjunctival insensibility, though there was slight reflex movement of the eyelid on the right side. The breathing was 30 per minute, regular, very deep, and at each inspiration the nostrils were pulled together so as nearly to close; and the corners of the mouth were drawn very forcibly downwards and outwards. In expiration there was blowing out of the cheeks on both sides, with

gradual formation of a white foam. During each expiration the spasm in the arms and legs was seen to increase somewhat, and to relax slightly with the inspiration. Pulse 144, rather irregular; no valvular disease to be detected with the stethoscope. There was not a trace of consciousness; tickling or pinching did not in the least degree increase the spasms. These seemed at intervals slightly to lessen, but never to disappear, and would then recur after a few seconds. A few teaspoonsful of water were poured into her mouth, the greater part ran out, a little was with much difficulty swallowed. The rectal temperature was 101.2 . She was ordered sinapisms to the back of the neck, and Pot. bromide and Ergot mixture. She died at 2.55 p.m.

P.M., twenty-one hours after death: Lungs, normal; liver, normal; spleen, normal. Kidneys: Right showed two cysts, the size of peas, under the capsule containing urine-coloured fluid; capsule adherent, tearing away some of the kidney tissue; kidney surface, granular; cortex diminished in thickness; left kidney similar, but no cysts. Heart: Some white thickened patches on visceral pericardium, no valvular disease; slight dilatation of aorta; on reflecting scalp there was a little subcutaneous blood effusion over the occipital protuberance; dura mater, normal. There was blood clot seen in small quantity in front of the medulla in the subarachnoid space, filling the fourth ventricle, and spreading from this in a thin layer under the cerebellum. The lateral ventricles were full of bloodclot. On examining the arteries at the base, a sacular aneurism was detected on the left middle cerebral, about the size of a large pea, it was situated just at a bifurcation in the fissure of Sylvius, about an inch below its origin from the internal carotid; it projected from the brain side of the vessel, and was embedded in the nervous tissue, and had ruptured close to the neck of the sack, and discharged the blood into the left lateral ventricle.

The point of interest about this case was the superficial resemblance of the symptoms to those of strychnine poisoning: the arched neck, the locked jaw, the universal spasm, at intervals somewhat remitting in intensity.

The diagnostic signs were: 1. The profound coma; in poisoning the mind is clear. 2. The expiratory blowing of the cheeks. 3. The absence of complete resolution of the spasm. 4. The abolition of the reflexes; in poisoning these are exaggerated, so that tickling or pinching, or even a puff of air will excite a spasm; the pupils do not act, in poisoning these are sometimes dilated during the paroxysm, and contracted during the resolution, here they were persistently contracted.

A CASE OF HÆMOPHILIA.

By JAMES W. HOPE, F.R.C.P.E., SURGEON
FREMANTLE PRISON, WESTERN AUSTRALIA.

THE family history I gathered from the mother of my patient who herself has not the diathesis. Of her grandparents she has no knowledge, her mother was not a bleeder, her father died from drowning when a young man, and was not a bleeder so far as she knows. She and her family until recently lived in South Australia. Her four brothers are or were bleeders.

John B. always a bleeder, nearly bled to death from a rat bite and, during convalescence, died from a carriage accident, at the age of 12.

Wm. B., at the age of 6, had lithotomy performed and bled to death at, or immediately after, the operation.

Two living brothers, aged respectively 24 and 20, both suffer from frequent severe epistaxis. The elder one nearly bled to death after the extraction of a tooth, and any wound is followed by considerable bleeding.

My patient is one of a family of six—four girls and an infant brother. The girls have shown no sign of the family taint. The younger brother is too young.

Albert C. Crewe, aged 6, since early life, has bled a good deal from trivial wounds. Last Good Friday he fell and cut his upper lip, he did not lose much at the time, but the following day the wound oozed continuously, and after a couple of days advice was sought. He had also been bleeding from the nose for 24 hours. He was perfectly exhausted and blanched. The bleeding from a jagged wound of lip was continuous, but a bandage stopped it from the lip, and in a couple of days it had ceased from nose, and he soon got back his usual condition of a well-nourished, fair, intelligent child.

On July 13 he got a punctured wound in thigh, just above the knee. In a day or two the leg became swollen and painful. He was seen on the 17th; then the leg from hip to calf was greatly enlarged, acutely painful and bent at knee. T. 108. He had been bleeding from nose and was very exhausted. Poulticing over seat of wound caused next day a discharge of broken-down blood, which became freer on succeeding days, the temperature fell, and the leg got smaller. Epistaxis gradually ceased. To get the leg straight I daily applied a little pressure over knee, and one day I put on a little more pressure and got it nearly into its normal condition, but shortly afterwards he experienced great pain, and soon the leg was as swollen as before, bent at right

angle, and temperature rose above 108 deg. F. A large blood tumour formed in popliteal space; this sloughed, leaving a large ragged wound. Large clots discharged from this for some days, and then the discharge became somewhat purulent, and gradually ceased. The leg got to its normal size, but the wound is not yet quite healed. To bring the leg straight I applied continuous pressure by means of a weight hanging over end of the couch, and this has nearly overcome the malposition now.

The second swelling of leg was due to effused blood, produced by stretching of contracted tissues. The mother remarked that she has usually observed the loss of blood to be trifling at first, and the continuous drain begins in about a day following the hurt. If this be true, and an unusual thing, it looks as though the capillaries got plugged as usual shortly after the injury, and that when the inflammatory reaction set in the weak vessels by their thickened media and intima interfering with their contractibility, the increased blood pressure overcame the plugging. This would only apply to bleeding from traumatic origin.

Bartholow was the first author I read who recommended ipecacuanha in bleeding from the lungs. Ringer also recommends it for the same purpose and for epistaxis. I have had the happiest results from such treatment in cases of the above. I have had cases of persistent epistaxis and purpura lately, in which I have used most of the hæmostatics, such as iron, ergot, hazeline, sulphuric acid, lead, gallic and tannic acid, without apparent benefit, whereas after a few days' treatment with ipecacuanha the bleeding ceased, and there has been no recurrence now, some months since treatment. In one case of epistaxis (a lad of 12) the loss had been a habit of years. I often combine liquor arsenicalis with it, for a tonic effect, but it may also have had an influence on the bleeding.

In the case of hæmophilia narrated, the nasal bleeding ceased after taking ipecac. for a couple of days in the first and second attacks, and I believe checked the loss from other quarters. I cannot explain its action, but I am convinced that in ipecac. we possess a powerful means of arresting bleeding whether general, as in hæmophilia and purpura, or local, as in epistaxis, hæmoptysis, hæmatemesia, &c.

A paper, by Dr. Jas. Graham in your July number, contains all that is known about this obscure disease, to which I can add nothing, the family history confirms the immunity of the females so far, in the freedom of the mother and her daughters from unusual loss of blood.

Fremantle, West Australia,

August 24, 1887.

DIGESTIVE FERMENTS AND PRE-DIGESTED FOOD.

READ BEFORE THE QUEENSLAND MEDICAL SOCIETY.

By J. LOCKHART GIBSON, M.D., EDIN., FORMERLY
SENIOR DEMONSTRATOR OF PHYSIOLOGY IN
THE UNIVERSITY OF EDINBURGH.

I HAVE been asked to read a paper on the digestive ferments this evening as an introduction to some demonstrations of the action of these ferments on the different food-stuffs. I avail myself gladly of the opportunity to speak on this matter, for I think we have, in the different carefully prepared digestive ferments now at our disposal, most important aids for combating disease; and with, I am sure, you all, I am glad to give Mr. Shepperson, as agent for Messrs. Borroughs, Wellcome & Co., an opportunity of demonstrating the peculiar value of some of the digestive preparations of his firm, for we must all feel indebted to it for having supplied us with these ferments in forms so simple that we can cause even the most uneducated amongst our patients to, when necessary, pre-digest their food-stuffs for themselves. It is this quality which makes the preparations of the firm so valuable, and which is causing them to supplant, at least in private practice, the well-tried and very valuable preparations of Benger. It was Benger, however, who supplied us with the first reliable preparations in his liquor pepticus and liquor pancreaticus, and it was with these that Dr. Roberts, of Manchester, made most of his observations on artificial digestion, which have been the chief cause of the extensive and gradually increasing employment of these agents by physicians.

I am not, to-night, going to put forward a plea for the use of digestive ferments and pre-digested foods, for in my opinion the value of both has been placed entirely beyond question. I have used Benger's preparations ever since my student days, and have not the least hesitation in saying that they have, in my hands, been the means of saving life when nothing else would have been of value, and I have little doubt that every physician who has used them at all extensively can say the same.

The classes of cases in which preparations of the digestive ferments are invaluable are—

1. Those cases where the digestive juices are deficient in quantity or quality, and where, therefore, the organism is suffering from insufficient absorption of food-stuffs.

2. Those cases where the organs, whose duty it is to produce the digestive ferments, are inflamed or diseased and require rest.

3. Those cases where there is some obstacle, mechanical or otherwise, to the injection of food.

It is needless to say that such agents must be used with caution, and in suitable cases only, and gradually discontinued when the necessity for them disappears; for the digestive, like the other organs, if idle for any considerable time, begin only slowly to re-exert their powers when the artificial aids are removed.

The three great classes of organic food-stuffs are the proteids—being the albumens and their allies; carbo-hydrates—such as starches and sugars; and fats. In their natural state the varieties of these food-stuffs are indiffusible, that is, they do not to any appreciable extent diffuse or pass through an animal membrane, such as the walls of the stomach or intestine, into fluid on the other side of such a membrane, in the case of the stomach and intestine into the blood.

Digestion is the conversion of indiffusible into diffusible food-stuffs.

The carbo-hydrates are converted into dextrine, maltose, and glucose, the last two of which diffuse readily, and it is in these forms that the carbo-hydrates are absorbed into the blood. The digestion of the carbo-hydrates, though commenced in the mouth by the ptyaline of the saliva, is most actively carried on by the amyloidal or starch-converting ferment of the pancreatic juice.

The albumens are converted into diffusible albumens, or peptones, in the stomach and alimentary canal. In the stomach, by the hydrochloric acid of the juice, under the influence of the catalytic ferment, pepsin, after passing through intermediate stages, the most important being that of acid albumen. They are acted upon even more powerfully by the proteic ferment of the pancreatic juice, which, strange to say, exerts its influence in an alkaline medium. Although, *a priori*, one would be inclined to think it acted by enabling the alkaline constituent of the juice (chiefly carbonate of soda) to transform the albumens, first into alkali-albumens, and then into peptones, that has not been definitely proved. Some of the peptones are, when the action of the juice is long continued, still further converted into leucine and tyrosin.

The importance of the pancreatic secretion to the digestive process cannot be overrated, as it acts upon all the classes of organic food-stuffs, having, in addition to its action on carbo-hydrates and proteids, an important action on fats. It decomposes them, splitting them up into their fatty acids and glycerine, and emulsifies those which it does not split up.

Fats are not absorbed into the blood like the other food-stuffs. They are taken up by the lymphatics, chiefly by those of the intestinal villi,

and in order to pass through the mucous membrane into the origin of the lymphatics in the villi, they have to be split up into very small globules, which is done by this process of emulsification.

The bile salts help the pancreatic juice somewhat in emulsifying fats, but the chief action of the bile seems to be antiseptic, purgative, and stimulant to the intestinal villi.

Milk, as an example of a natural emulsion, is shown under the microscope, and contrasting with it some popular oil emulsions—among them Kepler's cod liver oil and malt extract—in which the oil is even more perfectly emulsified than in milk.

As to the use of the different digestive agents at our disposal—

For the digestion of starches, vegetable diastase, as found in malt extract, is the simplest and best, for it can be given by the mouth.

For the digestion of proteids we have two methods, viz.:—either we assist the gastric juice, or we pre-digest them. To assist the gastric juice we give either pepsine, hydrochloric acid, or both, according to the requirements of the stomach. To pre-digest the proteids we use the pancreatic secretion, as its proteic ferment, trypsin, acts more quickly than pepsine, and by it we may digest milk, beef-tea, or eggs most simply and easily, and make them quite agreeable to our patients. This means of digestion is of great value when nutritive enemata have to be had recourse to, for by pre-digesting milk, or milk gruel, or beef-tea with the pancreatic secretion, either by Benger's liquor pancreaticus and carbonate of soda, or by Fairchild's zymine (so-called) and carbonate of soda, we are able to inject into the bowel food-stuffs which are so in reality, and which can be readily absorbed by the blood-vessels of the large intestine. And yet we still occasionally hear of *nutritive enemata* being given without any previous digestion, the value of which as food to the patient must be practically *nil*.

I must say a word about one preparation of Fairchild's which we often see advertised and much vaunted, viz., "Pancreatic Tabloids." These tabloids, when given by the mouth, are at least useless for digesting albumen, for the pepsine and acid of the gastric juice digest and destroy the trypsin or proteic ferment. It is said by some, however, that they have seen benefit follow their use. Perhaps this might be explained by the fact that the acid of the juice was deficient or absent, but the proper remedy for that would be the administration of an acid. I cannot speak personally for I have never given these tabloids, as I consider their use would be extremely un-

physiological, and unphysiological treatment is always bad.

There is a preparation here of trypsin, the isolated proteic ferment of the pancreatic juice. For ordinary digestive uses there is no advantage in having this ferment apart from the other ferments of the juice, but for digesting diphtheritic membranes, &c., it will be of value. I have used liquor pancreaticus for this purpose with advantage.

The action of zymine (pancreatic extract) upon starch, milk, and fibrin was subsequently demonstrated very successfully; as was also the action of scale pepsin and hydrochloric acid, both alone and together, upon fibrin. The action on starch of vegetable diastase, as found in malt extract, was also demonstrated, as also the action of the various constituents of the pancreatic secretion in emulsifying fat.

OSTEOTOMY FOR BENT TIBIÆ.

READ BEFORE THE N. S. WALES BRANCH B.M.A.

By C. P. B. CLUBBE, L.R.C.P. LOND.,
M.R.C.S.E., HON. SURGEON SICK CHILDREN'S HOSPITAL, SYDNEY.

OSTEOTOMY for the purpose of straightening bent tibiæ is an extremely easy operation. During the last two years I have operated on nine children for this purpose, and both legs were straightened in every case but one. In these cases, then, the tibia has been divided 17 times, and so there have been 17 compound fractures without any untoward result, for every child got well without a bad symptom. From the photographs which I have taken before the operations you will be able to see the extent of the deformity, and from those which were taken subsequently, which will be handed round side by side with the former ones, you will be in a position to judge the success of this mode of treatment. In nearly all the cases the curve was most marked laterally, with bow outwards; in some there was an antero-posterior curve as well. The last case I operated on about ten days ago there was a slight lateral, and a most marked antero-posterior curve in the lower third of the leg. These cases with the double curve are more difficult to deal with, and it is not always possible to correct the deformity by simple division of the bone. The ages of these children varied between two and three years—I was two

years, 8 were two and a-half, and 5 were three years old. The cause of the deformity is probably always due to rickets, or a condition allied to rickets. You find the child has either been fed on starchy food from the very earliest period of its life, or it has been kept at the breast too long, and so, after a time, has lived on milk of an inferior quality to the exclusion of more nourishing food.

I need not go into the details of each case. It is sufficient to say that no ill effects followed any of the operations. The wounds healed in a few days, and there was no rise of temperature in any of the cases. I generally do both legs at the same time.

I perform the operation in this manner:—Antiseptic precautions are taken, but the spray is not used. After sponging the leg with whatever antiseptic is used, the crest of the tibia is felt for, and a sharp-pointed tenotomy knife is passed across its inner surface at a point as near as possible to the centre of the curve. A blunt-pointed tenotome is now introduced, and with it the periosteum is divided. In bringing out the tenotome the opening in the skin should be made large enough to admit the saw, which is now used. In sawing there is sometimes a little trouble in judging whether you have sawn far enough through the bone. When you think you have accomplished this the saw is withdrawn, a piece of lint dipped in the antiseptic solution is placed over the wound, a towel is wrapped round the leg. Then grasping the leg with both hands—one at the knee and the other at the ankle—and using your own knee as a fulcrum, you pull till you hear the tibia give way with a snap; then pull on a little till you have straightened the fibula, which does not usually break. Very often considerable force has to be used before the tibia breaks, and sometimes it cannot be done without first sawing a little more. After the leg is straightened some antiseptic dressing is applied, and the leg is placed on an ordinary back splint with a foot-piece, and is kept straight by means of side splints which are secured by little straps of webbing. If all goes well, and there is no rise of temperature, the legs are left alone for four or five days, then when the dressing is taken off the wound is nearly always found to have healed. The legs can then at once be put in plaster of Paris. I generally keep the splints on my cases for about a fortnight before putting them up in plaster. Six weeks after the operation this can be taken off and the child allowed to use its legs. Children of this age, after having been off their feet for six weeks, will not begin to run about at once. They sit and crawl about, and only gradually begin to walk again, which is just as well. I always use the small saw, which I now show you, for these cases.

Some men prefer the chisel, because with that instrument they get less debris; practically, however, the "bone dust" does no harm.

Where the antero-posterior curve is very marked it is probably better to take a wedge-shaped piece of bone from the tibia with the chisel, as it is not easy to get the bones into position after simple division. Against this proceeding must be urged the fact that it increases the risk of the operation and shortens the leg. So if a wedge is taken from one leg the other should be treated in the same way.

Is osteotomy for bandy legs in young children justifiable? Many men think it is not. Owen, in the article on Bow-leg, in Heath's Dictionary of Surgery, says—"Osteotomy for bandy legs of little children must be very rarely necessary." And again, in his Surgical Diseases of Children, he says—"Osteotomy for bent tibiae should not be undertaken without due deliberation. I have seen pyæmia and death follow the operation, when performed by a careful surgeon, with all Listerian precautions."

We allow that there is a slight risk in the performance of this, as indeed there is after any operation; but the percentage of deaths after osteotomy for bent tibiae must be very small indeed.

The arguments in favour of the operation are these: The cure effected by this mode of treatment is speedy—the child can run about again, and with straight legs, in two months. When the treatment is by splints alone they must, if they are to do any good, be worn for months, and must be very firmly applied; as a consequence, pressure sores are frequently produced, and the treatment has to be interrupted. If no splints are used the child must be kept off its feet for at least a year. At the end of that time the legs may, and often have, grown straight; but supposing they have not, the child has been off its feet and has been kept sitting and lying about for a whole year, and then after all it may have to have its tibiae broken if it is ever to have straight legs. Besides this, many of the children with bandy legs belong to people of the lower orders, who cannot and will not keep their children off their feet for 12 months. A child of three years cannot be kept off its feet unless it is tied down, and children of this age have a most wonderful way of getting out of splints when their mothers' backs are turned.

That there is some slight risk in connection with this operation is a fact that is never concealed from parents, and they, wisely I think, with the prospect of the speedy cure, readily accept this risk rather than choose the safer but tedious course of treatment, which must deprive their little ones of the use of their legs for many a long and weary month.

THYROIDECTOMY.

READ BEFORE THE N. S. WALES BRANCH B.M.A.
By G. E. TWYNAM, M.R.C.S.E., L.R.C.P. LOND.,
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E. N., aged 21, a strong, healthy girl, was sent to me by Dr. Mackenzie in Dec., 1885, with the following history:—

Four years previously, when 17, she noticed a swelling in the left side of the throat, which increased in size, but without pain. She was then living in Muscleebrook, and the swelling was painted with iodine for some months. A year later she went to Newcastle, when the same treatment was recommended and carried out carefully. During the winter of 1885, when in Maitland, she consulted Dr. Morson, who injected iodine into the swelling 7 or 8 times in three months, but the reduction in girth of the neck was only from 18½ to 18 in. During this time respiration was becoming more and more difficult, and she could neither hurry nor go upstairs without great inconvenience. In November, previous to her visit to Sydney, electrolysis was used, but can scarcely be said to have had a fair trial. Her parents were strong and never had gonorrhoea, nor did they suffer from rheumatism. Her home was in an open and healthy part of the country. She was admitted to the Prince Alfred Hospital on December 6, 1885. At that time there was a swelling situated to the left of the trachea, as large as a mandarin orange, elastic and moving with deglutition. The trachea was pushed well over to the right. Eyes prominent, with pupils dilated, also nasi dilated with rapid expansion on the least exertion. She had no dyspnoea when at rest, but on movement her breathing became stridulous. Heart impulse outside the nipple line, but the sounds were clear and healthy. Blood, on microscopical examination, normal, urine normal. At first she was treated with red iodide of mercury ointment, rubbed into the tumour, and exposed to the sun in the Indian manner, whilst potas. iodid. gr. v doses, was given internally. This treatment was so severe that it had to be discontinued.

On January 6, I cut down on the trachea and divided the isthmus, excising the small central portion between two ligatures, one of which is shown in the specimen produced, and I then freed the trachea from the attachments on the sides to the gland, in order that it might come forward as recommended by Mr. Sydney Jones, of London. The wound healed without any trouble, and she left the hospital on January 18th, her breathing at that time very little, if at all relieved.

She came to see me again in March, 1886, and

was re-admitted. At this time she was no better, and the tumour had, if anything, increased, especially downwards, so I decided to remove the one half.

On April 7th I made an incision along the anterior border of the sterno-mastoid from the thyroid cartilage to an inch above the clavicle. The sterno-thyroid and hyoid muscles, which were greatly stretched and flattened out, I divided transversely over the most prominent part of the tumour. Next by separating the parts from the capsule by a blunt director and my finger, I freed the superior thyroid artery and veins, which I tied *en masse*. The tying of the inferior thyroid artery was no easy matter, as it entered so far round towards the back of the enlarged gland. I tied the artery and the veins in two ligatures. A vein on the surface of the tumour was then opened to see if the vessels were properly secured. This bled freely, which I found to be due to the middle thyroid veins, and in freeing them the sheath of the carotid vessels was torn and the jugular vein exposed. A small branch bled very freely, but ceased on pressure. This was the only sharp hæmorrhage that I had. By raising the tumour forwards from the vessels across the trachea, it was removed, and in doing this the large cyst at the back burst, which considerably reduced its size. Wound was washed out with corros. sublim. solution, and a good-sized drainage tube inserted by the side of the vessels, and another small one in front, above. The trachea, owing to the pressure of the large cyst behind, was found to be no larger than the neck of an 3 viii. bottle. She was placed in bed with the head raised and bent forwards, that any discharge might drain easily. A quantity of thin, serous discharge came away for two days, but the wound healed well. The temperature never rose above 100·6 (which was the day after operation) until the tenth day, when it rose to 101, which was due to small collection of pus anterior to the trachea. Pulse 100. No tremors were observed throughout. She left the hospital on April 27, well, except for small sinus, from which a silk ligature has since been discharged, and it has now closed. The effect of the operation has been to entirely relieve her breathing, even on exertion.

The surgical treatment of a case of enlarged thyroid body is one which gives considerable trouble and anxiety, and in these days must be associated with the question of myxoedema, so elaborately worked out by Mr. Victor Horsley, and published in the January numbers of the British Medical Journal for 1885. The possibility of the onset of such a condition made me at first hesitate to remove it. I think it may be said that he proves a distinct connection

between the presence of the thyroid body and myxœdema—a condition in which there are atrophic changes in the nervous system and fat generally—whilst the connective tissue, as a whole, is increased with mucoid conversion of its ground substance. Enlargement of the gland may be due to simple inflammation, adenoma, or hypertrophy—malignant new growth or cystic degeneration. The first must be treated as any inflammation, whilst for malignant growth removal may prolong life for a time. It is with the second form of adenoma or hypertrophy, with or without cystic degeneration, that we are most interested in as surgeons, for if counter irritation and iodide internally do not reduce it, treatment resolves itself into seton, injection or excision of part or of the whole gland. Treatment by seton is now rarely used. Simple aspiration does not succeed, as the swelling refills so rapidly. Injection of an alcoholic solution of iodine gives good results sometimes, but not infrequently it fails, and hence Dr. Morell Mackenzie has lately recommended the injection of the cyst with a solution of perchloride of iron through a canula, which canula is to be retained for six weeks. I have now a case under my care, whom I am treating with the liq. arsenicalis hydrochloricus, as lately recommended in the *Lancet*. If this fails I propose to cut down on the tumour until I can get clear of the veins, and then inject it. One important risk of injection (*viz.*, whether the end of the canula is in a vein) may be avoided by waiting to see if blood flows through the canula before injecting. Others consider that it is a dangerous proceeding, as the attachments of the cysts are apt to bleed, and may be very difficult to secure. Dr. Mayo Robson also supports this plan of treatment.

To sum up my case: counter irritation and injection both failed, and the position of the large cyst being so deep in, it could scarcely be detected. The simple division of the isthmus did not succeed, as the pressure came from behind, so that her condition finally compelled me to remove the one lobe.

The case is interesting for three points.

(1.) Because it is an instance in which the course suggested to Mr. V. Horsley by Mr. Sydney Jones, of removing the isthmus and so setting the trachea free, failed distinctly, as the breathing was not relieved nor did the tumour decrease.

(2.) The small size of the trachea, which was noticed by all present immediately the tumour was removed, may help as a trifle towards settling the question raised by Kocker, that the condition of myxœdema (including tetany, and fibrillation of the muscles) are the physiological symptoms of chronic asphyxia. The narrowing of the trachea—consequent on softening and atrophy due to the

ligaturing of the arteries supplying it, which is done at the time of operation, since the thyroid arteries supply the trachea—being the cause of the asphyxia. Such a branch on the side of the trachea was the last vessel twisted by me during the operation. It seems to me, my patient, with so small a trachea, should have shown signs of the disease with her prolonged dyspnoea, if the condition depended simply on the asphyxia and not on the removal of the gland, as “Kocker” seems to affirm. She did not show any signs of it whilst her thyroid gland was intact, although she certainly suffered from a condition that may be termed chronic asphyxia. Examination now will, I think, show that the trachea is expanding since the pressure has been removed, and that my patient shows no signs of myxœdema.

(3.) The third point of interest is that as yet, although the operation has been done some fifteen months, there does not seem to be any compensating hypertrophy of the other lobe—in fact, it is if anything, rather difficult to feel. Three months after operation the blood was normal and there was no enlargement of the spleen.

In conclusion I wish to thank Dr. Goode and my colleagues for their valuable assistance during the operation.

PROCEEDINGS OF SOCIETIES.

NEWCASTLE MEDICAL SOCIETY.

At the first annual meeting of this Society, held at Newcastle (N.S.W.), on September 16, the President (Dr. Cosby W. Morgan) delivered the following

PRESIDENTIAL ADDRESS.

GENTLEMEN,—I have to perform to-night the last act of presidential duty, that of delivering an address, prior to vacating the chair to which you did me the honor to elect me last year. I will first briefly review the circumstances of the formation of our association, and the work that we have accomplished during the past twelve months. The formation of the Newcastle Medical Society was initiated on the 16th of September last, of which to-night is the first anniversary, at a meeting of the medical profession of the district of Newcastle. There being ten legally qualified medical practitioners present, who enrolled themselves as original members. It was then carried unanimously that it is desirable to form a local medical association in the interests of the profession of the Newcastle District, and for the advancement of medical science among the members, and a committee was formed to draw up the rules, and to meet in a fortnight. The rules were brought up in due course, the name of the new association was decided upon, and thus the Newcastle Medical Society was floated. Its expressed objects were: (1.) The promotion of a cordial professional relationship between the members. (2.) The advancement of the science and practice of the various branches of medicine, surgery and obstetrics, by means of essays, papers, and reports of cases, and exhibits, with discussions thereon. (3.) The consideration of such questions as may affect the interest of the medical profession in the colony at large. Following the adoption of the rules, I was

elected your president for the current year, and Dr. Ashe kindly consented to act as secretary and treasurer. There were altogether 18 original members on the roll—a not inconsiderable number for a country district in Australia. Since that time five additional members have joined; but we have to sincerely regret the departure of our valued friend and colleague, Dr. W. C. Ashe, who has left the district for fresh fields and pastures new. There have been in all eight meetings during the past year, at which the following papers have been read and discussed, viz.:—

(1.) "On injuries of the urinary bladder," by Dr. Chas. Hedley. (2.) "Report of a case of idiopathic tetanus," by Dr. F. H. Bonnefin. (3.) "On intercranial tumour," by Dr. Stapleton. (4.) "On trephining the mastoid cells," by Dr. J. L. Beeston. (5.) "A case of imperforate hymen with obscure abdominal tumour," by Dr. O. W. Morgan. (6.) "On gastric ulcer," by Dr. W. C. Ashe. (7.) "On injuries of the knee-joint," by Dr. J. B. Nash.

There have been exhibited at every meeting pathological specimens of extreme interest, which have been productive of the interchange of a great deal of practical and scientific detail. It is to be regretted that on several occasions there have been difficulties in the way of our meeting, and the society has had to regret the occurrence of severe illness of several of the most active members, Drs. Hedley and Beeston having each suffered long and alarming attacks of typhoid fever, and Dr. Ashe having also been laid up from illness. The demand on the time of the members by the exigencies of large and active practice has also made it impossible to obtain a quorum, and on some occasions meetings have fallen through. Some questions of importance to the profession at large have engaged the attention of the society, among which may be mentioned the advisability of permitting unqualified practitioners to give evidence at coroners' inquests, and on this subject the society respectfully addressed the Minister for Justice of the day. The necessity for legislation on medical subjects was discussed at a recent meeting, on which occasion a vote of thanks was accorded to the Hon. J. M. Creed, M.L.C., for the able manner in which he had conducted the business of the special committee of the Upper House of Legislation on "Unqualified Practice." It was also carried that the society considered the introduction of a Medical Bill should be undertaken by the Government in preference to a private member. Another matter on which the members of the society considered it to be their duty to express an opinion was that of the dastardly attack on the character of Dr. H. G. A. Wright, of Sydney, and, by a unanimous vote, a letter of congratulation was sent to Dr. Wright on the triumphant vindication of his character, which had been assailed by a disgraceful conspiracy. The members further conveyed their respectful condolence on the loss he had sustained by family bereavement. Dr. Wright's case is one that enlists at the same time the indignation and sympathy of every right-thinking member of our profession, and shows us that even the most immaculate and honourable are not free from cruel and undeserved aspersion, and that the long unblemished career of a kindly and high-minded gentleman is no safeguard from the attacks of sordid and ruffianly men nor of depraved women. What was Dr. Wright's undeserved misfortune might be that of the most chaste of us at any time; and it is in such cases of vile aspersion that a good man's life commands the brotherly sympathy of the profession at large. Another event indirectly connected with our society during the year has been the Intercolonial Medical Congress at Adelaide, which was notified to us by the secretary,

Dr. Poulton. As the congress did our society the honor to elect me, as your president, to be one of its vice-presidents, it was my intention to have been present and to have represented the society, but a criminal trial, at which I was compelled to attend, prevented me. The report of the proceedings have not been published yet, but I believe the congress was well attended and will be productive of good results to the profession. I observe that the next Intercolonial Congress is to be held in Melbourne in two years' time, and it is probable that the third rendezvous will be in our own colony. These gatherings of the profession from the various colonies should be the means of knitting its members together by a strong bond of union. One result that may be hoped for is that a uniform Medical Act may be passed by the legislatures of all the Australian colonies, for at present the laws relating to medical practitioners are very faulty, and in this colony virtually a dead letter, the few Acts that we have in existence being frequently over-ridden and disregarded by those who administer the law. It is not unusual for Judges to accept the sworn testimony of ignorant and unqualified practitioners, even in cases where the life and liberty of the subject are at stake. It frequently happens that, in defiance of the Medical Witnesses' Act of 1838, unqualified medical men are permitted to give evidence at coroners' inquests, and to be paid as if they were entitled to the remuneration specified by the same Act as pertaining to legally qualified practitioners. There can be no doubt that a comprehensive and liberal Act ought to be passed to enable the public to distinguish between qualified and unqualified practitioners, and to define the duties of the medical profession in all matters connected with the mutual State. At the present time the relationship of the profession and the State is unsatisfactory, and the subject is one that should be discussed during the ensuing year. I therefore commend it to the consideration of the society. It is usual in an address such as the present to revert to the various advances that have been made in science and practice during the past year. I will therefore briefly mention some of the most important features of medical and surgical progress. I think the foremost of all must be considered the subject of brain surgery, and with this we must couple the name of Mr. Victor Horsley, of London, who has advanced the importance of the subject of cerebral localisation in cases of epilepsy with a view to operative procedure, his suggestions have found general favour, and it is satisfactory to know that Mr. Fitzgerald, of Melbourne, has operated with good results on Mr. Horsley's lines. Operations of this character will, no doubt, be brought into the practice of many of the members of our own society. Brain surgery is only in its infancy; it forms a bond of union between the physician and surgeon. The study of pathological anatomy and accurate diagnosis on the part of the physician meets on neutral ground with the operative treatment of the surgeon. To the favourable results of these operations antisepticism has greatly contributed, and the after results of severe operative procedures are now fairly controllable. It is, in fact, the case that trephining, which some years ago was rarely resorted to, is now of constant occurrence for exploration and relief of the brain. The cases read before our society by Dr. Beeston, in which the trephine was used for the relief for diseases of the mastoid cells and middle ear, are in accord with the advance of brain surgery. Second only to the advance of the surgery of the brain is that of the abdominal cavity. The abject terror of peritonitis which possessed the surgeon of a few years ago has disappeared since antisepticism has taught us what can be done with impunity in abdominal sections, if

only careful precaution is taken. Cholecystotomy, gastrostomy, splenectomy; the removal of large abdominal tumours and cysts, with the gynæcological operations for ovariectomy, hysterectomy, and oophorectomy are all becoming common in modern surgery, and many of them have been successfully performed by members of our society, while exploration of the abdominal cavity in cases of obstruction is considered justifiable. The thorax is, in the present day, assumed to be fairly within the province of the operating surgeon, and to the puncture of the thoracic wall by the aspirating needle or trocar is now superadded the resection of the ribs and the bold incision into the pleura and even the pericardium. Nor must we forget the advances in surgical treatment of the bladder, among which we may mention Sir Henry Thomson's supra-pubic operation for the extraction of stone, and his digital exploration of the bladder in cases of villous tumour; and the post-prostatic puncture for relief of distended bladder as described by Mr. Howlett, of Hull, and successfully performed by Dr. Hedley, a report of which has been already alluded to. These are some of the indications of rapid strides in operative surgery; and happy may we feel that at this remote distance from the chief centres of surgical science we can carefully and successfully follow the lead of the great masters of our profession.

From surgery we turn to medicine, in which department I do not think anything has been advanced of such brilliancy or such marked importance as surgery has recorded during the past year; but I am convinced the only true lines we can follow in medical ratiocination are those of etiology and pathology—in other words cause and effect. The labours of bacteriologists will before long be productive of tangible results; and we must look forward to definite axioms and principles regarding the causation of diseases once supposed to be inevitable and incurable, which we shall find will be brought within the scope of prevention and cure. The labours of M. Pasteur in the treatment of hydrophobia are variously spoken about; and the report of the special commission of inquiry has given its verdict in favour of his system. I cannot myself regard the experiments I have read as being absolutely convincing, and consider the practice of inoculation as still on its trial. Some interest has been created in the anti-thermic treatment of fevers, by the administration of anti-pyrim, anti-febrin, thalline and resorcin; these are all undergoing accurate observation, and their merits or demerits have not been definitely decided upon. The anti-thermic treatment has been under our own observation in hospital and private practice during the last year. My own conclusions are that the system of pulling down the pulse requires the nicest discrimination in its management to be of real use in the issue of the case. The treatment of nervous diseases by hypnotics, urethane, and hypona as substitutes for chloral is recorded, and their value highly spoken of. Paraldehyde we already know, and I think this remedy has hardly sustained its reputation. Cocaine has been variously experimented with, and is now given internally as a sedative in a variety of cases. Some value may be attached to the use of pure terebene in catarrhal and asthmatic affections. Strophanthus is found to be of value in the treatment of cardiac affections, increasing systole and making the action of the heart slower. The treatment of phthisis, rheumatism, diabetes, and albuminuria have each had their exponents during the last year, and the journals have thrown much new light on these and a variety of other medical subjects.

I will now pass on to our own special position as practitioners. We are precluded by the nature of our daily life from devoting a great deal of our time to dis-

covery, or to the active pursuit of exact science, but we have an ample field for our energies and daily opportunities of utilising the knowledge we have acquired for the benefit of those whose lives are entrusted to our care; and on us is imposed the duty of recording results, than which nothing can be of greater practical value. Perhaps I may be pardoned for introducing a few remarks from an address of Mr. Claudius Wheelhouse on the position of the general practitioner with reference to the work of the profession, delivered at the annual meeting of the Yorkshire branch of the British Medical Association in July last. He says: "Let us think of the general practitioner in the work of everyday professional life. Beyond all dispute he is the backbone of the profession; to him it is that the public must, and do, look for that ever ready sympathy which ministers not only to their graver and more serious illnesses, but to the more transient aches and pains and lesser discomforts of their daily lives, which makes him in fact the ready servant, the sympathetic friend, the skilled adviser, the trusted and intelligent confidant of every family he is called upon to enter, and the member of society whose place could in no other way be supplied. But if these were his only functions, he would be doing no more than those who tread the easier and loftier walks of professional life. He would be only working in a different sphere and shaping his efforts to a different end. He has other opportunities for good, and if he fulfils them in the true spirit of the love of his profession, his labours rise to the dignity of work second to that done by no man. His it is to watch the evolution of all forms of ordinary disease; his to take note of the cause and tendencies of epidemics; to watch, to note, and to make known all the variations assumed by common disease; and his to start the workers in the so-called higher grades of teaching—the physiologist, the bacteriologist, and even the specialist in their various and useful walks of life. By whom, if not by the general practitioner, has public medicine been brought to the standard to which in our day it has attained? Who but the general practitioner has tracked out the devious and insidious pathways by which diseases and death enter our houses, and then our families, carrying off those who are our dearest; and who but he with sword drawn stands ever on guard, ever ready to bar their entrance? What has become of the age of our forefathers? What has become of the smallpox which formerly decimated the world? What of the fatality which in former times marred all the best surgical work of the world and dogged the footsteps night and day of the most careful obstetricians? To whom, if not to the general practitioner, is the world's victory over all these to be ascribed? To stand as a unit in the great army of workers for the public good is a privilege of which we may, every one of us, be justly proud; and, whenever I am asked for the patent for the true nobility of my profession, I point proudly to public and preventive medicine as a work greater than that accomplished by any other section of the community." I cannot but regard these words as of great encouragement to ourselves, who belong to the rank and file of the medical army. The race is not always to the swift, nor the battle to the strong, and success or eminence in our professional career may be attained by one man, who may have settled in the metropolis, while it is the lot of another in the country to achieve nothing more than mediocrity, or the most modest wealth. This should not discourage the country practitioner, for his work, if thoroughly done, places him in as good a position relatively as that of the specialist, or the pure physician or surgeon; nor do I think his lot, if less brilliant, is without its compensating advantages. The country

practitioner has written his name in broad characters in the history of the development of these colonies during the Victorian era, which the present jubilee year has celebrated. Whether as a pioneer in the olden days, when his duties entailed upon him privations and hardships, and even personal danger, or as a denizen of some small inland township, now perhaps grown into a city with thousands of inhabitants, to whose progress he has contributed, and with whose prosperity he has been associated, the country practitioner has deserved well of the land of his adoption. He has supported religious, social, literary, and scientific institutions. He has cheerfully undertaken the thankless work and responsibility of civic duty. He has done good service to the State as a magistrate, and has thrown himself into the breach in the various military movements instituted for the defence of the colony. How much the social progress of this country owes to our profession can hardly be estimated. Nor have we ever grudged our service to the State; travelling long distances at great inconvenience and monetary loss, to attend Law Courts or to shed what light we could upon questions involving the life and liberty of the subject, or the maintenance of law and order. Nor in these days, when the subject of sanitary progress and hygienic law is becoming prominent, do we withhold our aid and advice in the cause of what we believe to be right and for the public good.

The profession, notwithstanding its work among the people, and the undoubted influence it exerts over a large section of the community, has its enemies and opponents. This is the age of great expectations—people run after the marvellous, and expect the impossible; it is, therefore, not surprising that the charlatan and the quack are in high feather—*Populus vult decipi, ergo decipitur*. The report of the commission of the Legislative Council, recently issued, contains an astounding record of the impostures to which the public submit, and shows in what shallow pretenders even intelligent men will put their trust. It is a well-known fact that in many instances large fortunes are made by the most ignorant of these men; and, furthermore, it is true that such people have the ear of many in positions of power and authority—and that our profession has to contend against much unjust attack and reprobation in consequence. We must, however, comfort ourselves under these circumstances by the reflection that the credulity upon which quackery imposes is an indication of ignorance and prejudice natural to unenlightened and superstitious minds, and that as the mass of the people and their representatives become better educated, they will cease to be imposed upon by impostors, and will learn to estimate our work. It may be mortifying to see the charlatan grow rich, and aspire to high places—the magistracy, the Legislature, or other positions of authority and power—but that should not discourage us from pursuing the even tenor of our way. Our path of duty to the public and to each other is clearly indicated, and truth must triumph in the end. Above all things, it is for us to be careful to avoid anything that may "give the enemy occasion to blaspheme." The profession should never imply a promise of more than it can perform, and any suspicion of qualified quackery should be expurgated from amongst us. Thus, with care and circumspection, attack would recoil upon itself, and our work would be appreciated at its true value.

In conclusion, I have to thank you for your courtesy and support during the past year, and to express my sincere good wishes for the future success of the society.

MEDICAL SOCIETY OF QUEENSLAND.

IN response to an invitation issued to the members of the society to attend a special meeting on July 27, 1887, when a paper was promised on "The Digestive Ferments" by Dr. Gibson, and a practical demonstration of the subject by Mr. W. H. Shepperson, travelling representative of Messrs. Burroughs, Wellcome & Co., the following gentlemen attended:—Drs. Bancroft, McNeely, W. S. Byrne, E. H. Byrne, Kebbell, Hardie, Lyons, Webb, Furley, Hare, Gibson, Shout, Mullen, Campbell, Taylor, King, and Love.

Dr. Clowes was present as visitor.

Dr. Gibson then proceeded to read his paper, which will be found on page 8. Drs. Taylor, Hardie, Bancroft, and others, joined in the discussion which followed.

A warm vote of thanks was accorded to Mr. Shepperson for the trouble he had taken in preparing the demonstration, which consisted of experiments shewing the action of pepsin, and symine, and trypsin on albumens, action of zymine on fats, etc., action of diastase on carbo-hydrates, etc, and microscopic slides of fat emulsions.

SOUTH AUSTRALIAN BRANCH OF THE B.M.A.

MONTHLY MEETING held at the Adelaide Hospital on September 29, 1887. Present:—The President (Dr. Davies Thomas), Professor Watson, Drs. Cawley, Lendon, Mackintosh, Poulton, Stirling, Wigg, Messrs. Aitkin, Corbin, Vaughan and the Hon. Sec. (Mr. Cleland).

The minutes of the meeting held August 11, 1887, were read and confirmed.

Ballot.—Alexr. Laurence, M.B., was elected a member of the British Medical Association and of its S. A. Branch.

Exhibit.—Dr. Lendon exhibited a boy (W. O'K.) set. 4, from whom he had removed a calculus weighing 58 grains by the supra-pubic operation. The child had retention of urine, followed by extravasation, a year ago. He had been sounded on two occasions without the stone being detected, and, as the symptoms of calculus persisted, he was sent by Dr. Borthwick into the Children's Hospital. A stone was found which seemed to be lodged behind the pubes and did not drop into the apex of the bladder when the child was inverted, hence the preference for the high operation, which was performed in the usual way, the rectum and the bladder both being distended. A drainage tube was left in the upper end of the wound for 48 hours and the rest of the wound brought together with superficial horse-hair stitches, with a good result. The child passed urine by the urethra for the first time on the 11th day, and after the 12th day none came through the wound.

Pathological Specimen.—Dr. Lendon exhibited a specimen and gave a brief history of a case of hydatid which originated in the spigelian lobe of the liver, and, after spreading out over the upper surface of the liver and attaining to enormous dimensions, had absorbed the diaphragm and burst through a bronchus of the right lung. Death resulted from flooding of the lung with hydatid fluid during an attempt to remove the cyst and its contents three days after it had ruptured.

The President reported that the committee appointed to consider the question of continuing the separate printing, or otherwise, of the proceedings of the Branch, was not prepared to make any recommendation. Two proposals had been received from the existing Australian Medical Journals and these he would lay before the

members, and it would be for them to decide which, if any, to accept. Dr. Poulton moved "That this Branch of the British Medical Association accepts the offer made by the editor of the *Australasian Medical Gazette* for the publication of its monthly proceedings." The motion, having been seconded by Dr. Stirling, was carried; and Dr. Poulton and Mr. Cleland were appointed local editors. The Hon. Secretary was also instructed to see on what terms the *Gazette* could be supplied to the members of the Branch, to replace the previous monthly issues of the proceedings now to be discontinued.

INFLUENTIAL REPRESENTATION OF THE NECESSITY FOR LEGISLATIVE ACTION BY THE GOVERNMENT AS REGARDS A MEDICAL BILL FOR NEW SOUTH WALES.

THE following letter was received, on September 23, by the Premier:—

Sydney, September 19, 1887.

Sir,—Whilst expressing our regret that your absence from Sydney on September 10 prevented us waiting on you as we proposed, we fear that the duties of our various offices will render it impossible for us to again assemble at such an early period as would make our interview of useful effect. Under these circumstances we therefore trust that you will pardon us when, instead of, as we at first intended, waiting upon you to make our representations in person, we convey them in writing. We desire to bring under the notice of yourself and colleagues, as forming the Government of this colony, the practical absence of any law in any way controlling the practice of medicine and surgery in New South Wales, or granting such protection to the public as would enable its members to ascertain promptly and surely whether persons practising as medical practitioners have really passed through the necessary course of training, or have really obtained the diplomas they claim to possess. The terrible evils consequent upon this state of the law have been so forcibly brought under our notice by the publication of the evidence given before the Select Committee of the Legislative Council that we feel it is but a duty incumbent on the occupants of the offices which we hold to make representations of the urgent necessity for such prompt legislative action as will remedy them. Feeling, also, that it is not advisable that a measure of such vital importance to the public well-being should be introduced by a private member, we most respectfully ask that you, as Premier, and the other members of your Government, will take the matter into earnest and early consideration, and that you will introduce a bill during the coming session of Parliament for the regulation of the practice of medicine and surgery in New South Wales.—We have the honor to be, Sir, your obedient servants,

Alfred Stephen, Lieutenant-Governor; Fredk. M. Darley, C.J.; Patrick Cardinal Moran, Arch-bishop of Sydney; Alfred Sydney, Primate; S. A. Joseph, President Sydney Chamber of Commerce; A. J. Riley, M.P., Mayor of Sydney; Chas. Bright, Chairman of Baptists' Union, N.S.W.; William G. R. Stephenson, President of Wesleyan Conference; Alexander Barnard Davis, Rabbi of Jewish Congregation in New South Wales; James Hill, M.A., Chairman of Congregational Union, New South Wales.

THE HONORABLE SIR HENRY PARKES, K.C.M.G.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castle-reagh Street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, OCTOBER 15, 1887.

EDITORIALS.

THE OUTBREAK OF SMALL-POX IN TASMANIA.

THE discovery of small-pox in Launceston is a matter of the greatest moment to the people of these colonies. If, in a city so little exposed to outside contagion, small-pox appears from some untraceable source of infection, what may be expected in those ports on the continent of Australia so much more intimately connected with eastern countries where small-pox is endemic. Similar outbreaks will occur again and again, and sooner or later the disease will have made such headway in one of the colonies where vaccination is neglected (New South Wales being, perhaps, the most careless in this respect) before it is discovered, that it will be impossible to control it, and the unfortunate victims will die in hundreds. The inconvenience to passengers and loss to the mercantile community which has arisen from the attempt to enforce quarantine regulations between the colonies, must lead to such energetic protest as will render its continued enforcement impossible. Nothing, perhaps, could be imagined which is more ludicrous than the practical lengthening of the voyage between Tasmania and Melbourne from twenty-four hours to fifteen days. The health authorities in Sydney, having received no information of any kind as to the outbreak and means taken for the isolation of the disease, very properly ordered the vessels arriving from there into quarantine, pending the receipt of particulars from the Government in Tasmania, but upon receipt of this, it being found that proper care was being taken, have since decided that vessels shall only be detained long enough for inspection and disinfection. The Melbourne Health Board with its lay chairman blindly following the lead set them by Sydney, however, still stick to their first unconditional decision that all vessels from

Tasmania must fulfil the usual quarantine. They will, however, we are of opinion, soon have to alter this.

There is but one way to avoid these ever recurring scares, which will be even more frequent as time goes on, that is to insure that the entire population is effectually vaccinated and re-vaccinated; then we should possess that immunity from small-pox which is possessed by American cities from the adoption of like precaution. The sole reason that this is not the case now is the unreasoning dread of ill-informed people of the phantasmal evils supposed by them to be consequent on vaccination. The most certain way to remove this dread would be by giving practical effect to the suggestion of the Editor of this journal in the Legislative Council of New South Wales on September 30, 1885: That a commission should be appointed, who would receive information as to particulars of any supposed cases of the evil results of vaccination, and search them to the bottom. Thus we should have definite knowledge as to the injuries produced by the operation, and not have, as at present, a number of vague statements by irresponsible persons flying around without means of proof of their truth or falsehood, and which, when searched into, in majority of cases, are found to have no just foundation.

THE SYDNEY SICK CHILDREN'S HOSPITAL.

THE unsatisfactory state of the management of the Sydney Sick Children's Hospital, which has been a source of acute trouble for many months, has been properly terminated by the dismissal of the matron, Miss Holden. This absolutely necessary ending has not been arrived at without what can only be fittingly designated "a row." The committee, after much provocation, decided that either Miss Holden must leave or that they would have to consent to her managing not only the department which was properly under her control but the committee and the honorary medical staff as well. They very considerably offered her three months' leave of absence on full pay, with the understanding that she was not to return to the hospital. This kindly offer she promptly refused and at once appealed with a typical feminine hysterical shriek to the public through the newspapers, considerable sympathy being expressed for her, on the case as presented by herself, by several writers whose heads are apparently even softer than their hearts. We read the correspondence carefully, and were with all unprejudiced persons, quickly convinced by her own

letters that she had no case and were of opinion that she was studying no interest but her own. The institution receiving pecuniary aid from the Government an enquiry was ordered by the Colonial Secretary, Mr. Whittingdale Johnston, S.M., being appointed to conduct it. The finding was that Miss Holden had failed to prove any of her recklessly made charges against the committee and the honorary medical staff and that, if the hospital were to be carried on, her dismissal was not only justifiable but inevitable.

Though Miss Holden was eager in demanding the enquiry, as soon as the finding was against her she incontinently rejected it and appealed to the general body of the subscribers through the ballot. In this she was beaten by three to one, and has now left the institution. As a matter of course much dirty linen has been washed in public, and people who should have known better have behaved in a manner which can only be justly stigmatised as disgraceful. Weak persons have been made tools of, and envy, hatred, malice and all uncharitableness have been rampant. The causes of the trouble have been, apparently, the presence of a matron who, preferring to be called "lady superintendent," considered it her mission to "superintend" everybody, the absence of a paid resident medical officer, and the selfish clannishness of an insignificant minority of the governing body. There is now a fair prospect of all these causes being removed and of a prosperous future for what may now be made a highly useful institution. When all the circumstances are known it seems wonderful that the final scrimmage should have been kept off so long. It broke out some three years since in a mitigated form, the then honorary medical staff, consisting of men of high standing, finding it necessary to resign in a body.

THE KIAMA (N.S.W.) COTTAGE HOSPITAL.

At a recent meeting of the Committee of this institution, a letter was received from the medical practitioners of the neighbourhood, asking that the privilege of sending patients into the hospital who were able and willing to pay the cost of their maintenance and nursing, but desiring to remain under the professional care of the practitioner sending them in, might be granted. It appears that there is a paid medical officer to the institution, and the committee allow this gentleman to exercise the right asked by the other medical men. After some discussion it was decided that, for the

present at all events, the request made could not be complied with. We think this decision a mistake in the interests of the hospital, and trust to hear shortly that the decision has been reversed.

In the management of a country hospital it is essential that nothing should occur which would raise unfriendly feelings towards it, or that the medical officer should not possess such exceptional advantages as would cause his professional brethren to feel justly aggrieved. From time to time cases must arise which need the assistance of more than one surgeon, and how can he in decency ask the assistance, in consultation or operation, of men of equally high standing with himself, who are placed in such a position that they must hand over serious cases to him for treatment in the hospital, or by retaining them under their own care necessitate their remaining in a place with unsuitable surroundings and with inadequate accommodation and attendance. No man who has practised in the country but must remember many cases of patients comparatively wealthy and well able to pay for professional attendance, who, if allowed to remain in the place where they have chanced to meet with the accident or illness which disables them, would have their prospects of recovery materially lessened to what they would be if treated in a hospital. It may be from distance from the surgeon, or from ignorance of nursing by the relatives, or from the insanitary condition of the house. Is it fair to compel such a person to change his doctor or decline to avail himself of the advantages of hospital treatment?

ACTION FOR NEGLIGENCE AGAINST AN UNREGISTERED MEDICAL PRACTITIONER.

In this case, the plaintiff, John Edgeworth, residing near Murrumburrah, sued Walter Horatio Allen, practising in that place as a medical practitioner, seeking to recover £100 damages from him on account of his negligence whilst attending the wife of the plaintiff during her labour. The defendant was called in by the plaintiff to attend his wife under the belief that he was a properly educated practitioner possessing diplomas, he having "Dr. W. H. Allen, Surgeon," on his door. The defendant arrived at his patient's house early on the morning of Saturday, the 19th March last, and apparently considered the case sufficiently urgent to necessitate his stopping with her until nine o'clock at night, when he left and went home. He was sent for twice during the night, but did not visit the woman again

until some hours after she had been easily delivered by a properly qualified practitioner, whom the friends had been wise enough to appeal to for assistance. It certainly was extraordinary conduct on the part of a man who had any knowledge of obstetrics to stay for many hours with a woman during the earlier part of her labour, and then to feel that he was justified in leaving her to chance during the later part when, if only from delay, matters must of necessity have become more serious. The evidence given by the husband states that Allen said the child was dead and would have to be cut to pieces, this shows that the defendant must have taken a serious view of the case, and that his leaving it was not justified by the belief that his presence was unnecessary. In cross-examination he said he had no diploma, and apparently did not claim to have received any very high-class training, mildly professing to have attended a medical college in America, and to have taken lessons in surgery, but chiefly basing his possession of medical knowledge on the extraordinary plea that "his father was demonstrator of anatomy at a college in St. Louis." The entire evidence demonstrated the miserable state of the law in New South Wales, which allows any man to deceive the public into believing he is a properly qualified medical practitioner with impunity. The jury delivered the extraordinary verdict—that the defendant had been guilty of negligence, but only gave a farthing damages. Anything more illogical than this impotent conclusion it is impossible to conceive, for if the man Allen was guilty of negligence, the unfortunate victims of such negligence were surely entitled to substantial compensation.

LETTERS TO THE EDITOR.

MEDICAL ETIQUETTE.

(To the Editor *Australasian Medical Gazette*.)

Dear Sir,—I wish to bring under your notice what I consider a gross breach of professional etiquette on the part of a brother practitioner here, the facts of the case being as follows:—

On Tuesday morning, the 2nd instant, I was called to see S. D., set. 49. He was of medium build, active, intelligent, and a farmer by occupation. He stated that about nine years ago, while shoeing a horse, he got his testicles squeezed, and that from that time onwards the scrotum had gradually enlarged from above downwards, until it had attained its present dimensions. On examination I found the scrotum enormously swollen, the skin red, and pitting slightly on pressure, but not adherent to the deeper parts. The outline of the testicles could easily be made out lying at the posterior part of the tumour, the right being somewhat lower than the left, and in close contact with the scrotal wall.

There was no impulse on coughing, and the tumour had a dense feeling, which the patient very aptly described like the sensation one feels on cutting an apple; and on examination by transmitted light the tumour was perfectly opaque. My diagnosis was that the patient was suffering from a chronic hydrocele of the cord. He then explained to me that, having been in Sydney eight days previously, he had consulted Drs. Marshall, sen. and jun., who evacuated the contents of the sac by means of a trochar and canula. The following morning the swelling had returned to its previous dimensions, and he again consulted Dr. Marshall, who again punctured it, and a little bloody fluid was evacuated. Dr. M. prescribed a lotion to be applied to the swelling and told him it would probably disappear in a few days. When I first saw him he stated that it was no larger than it had been previously, but that he had a disagreeable dragging feeling in the groin. I explained to him that frequently after tapping a hydrocele you would find a temporary swelling, and that it would probably disappear in about three weeks' time after the operation. The patient's temperature and pulse were normal, the tongue clean, but pale and flabby looking and somewhat enlarged. Instead of the lotion, I prescribed the compound mercurial ointment to be rubbed into the swelling twice daily, and internally the following mixture:—

R.—Sodii Iodidi gr. 30
 Liquoris Extracti Sarsae ... 3 i
 Syrupi Aurantii ... 3 ss
 Spiritus Ætheris Chlorici ... m xii
 Aquæ ad ... 3 iv
 Misce 3 vi

Sig.: A tablespoonful in water every four hours. I suggested that he should continue this treatment for about fourteen days, and if there were no signs of improvement he should submit to have the sac opened by an incision. To this the patient agreed, and I left saying that I would call on the following Thursday or Friday. The following morning the patient's son called to say that his father had taken suddenly ill about 4 a.m., complaining of an agonizing pain in his head, the back of the neck, and along his spine, and pains in his limbs.

On examination I found his temperature in the mouth 98° F. (subnormal), P. 64, respiration laboured, and the tongue covered with a brownish fur. He also complained of great pain in his eyes, with extreme sensibility to light. He was lying on his left side, head thrown back, the spine curved, thighs flexed on the abdomen and legs on thighs. No eruption on the patient. My diagnosis was epidemic cerebro-spinal fever, of which I may state that I have had several cases lately.

Having ascertained that his bowels had just previously been well cleaned out with a dose of sulphate of magnesia, I prescribed the following mixture:—

R.—Potassii Bromidi gr. 45
 Sodii Iodidi gr. 30
 Liquoris Hydrargyri Perchloridi (B.P.) 3 ss
 Spiritus Ætheris Chlorici ... m xii
 Syrupi Aurantii ... 3 ss
 Aquæ ad ... 3 iv
 Misce 3 vi

Sig.: A tablespoonful in water to be taken every four hours. At 9 p.m. the pain in the back of the neck and spine had almost disappeared, but he still complained of a severe headache. The temperature was now 100.6 F., P. 80, respiration free. As a sleeping draught I prescribed the following:—

R.—Sodii Bromidi gr. 30
 Chloralis Hydratis gr. 30
 Tincturæ Digitalis ... m v
 Spiritus Ætheris Chlorici ... m xv
 Syrupi Aurantii ... 3 ss
 Aquæ ad ... 3 iv m

Sig.: The draught to be taken in water at bedtime.

On Thursday morning he still complained of the headache, but had slept fairly well till 6 a.m., and was now able to be propped up in bed. His wife stated that she had been persuaded by some friends to get the advice of a second medical man. I asked her if she wished to get a consultation, or whether she wished me to hand the case over to any other practitioner. She said she merely wished a consultation, and it was arranged that I should meet Dr. Spencer in consultation at 11.15 a.m. I gave him the history of the case since the patient came under my care. Dr. S.'s opinion was that all the trouble arose from the scrotal swelling, and that an incision should be made at once. To this I demurred, as I considered that an operation in the patient's present condition was not advisable. He then remarked that as we could not agree, the opinion of a third man should be got. The patient was informed of this decision, when he replied that he was perfectly satisfied with my treatment of the case, and that he would not submit to an operation at present. We then left, and I returned about 4 p.m. to suggest that a third man should be called in. To my astonishment I was informed that Dr. Spencer had made arrangements with Dr. Bassett to operate at 4.30 p.m., the patient up to this being likewise ignorant of such an arrangement. He was informed of it in my presence, to which he strongly dissented, saying that he would not submit to an operation in his present condition. I represented to them the discourtesy that had been shown to me. Seeing that he was much improved to what he was on the previous day, I submitted that a few hours longer could not make any material difference; it was then agreed that Dr. Barber, of Mudgee, be the third man. This arrangement was communicated to Dr. Spencer. I stated that I would call at 9 p.m. to inform them what time the consultation with Drs. Spencer and Barber would take place next day. However, the patient's son called in the evening to inform me that Dr. Spencer had called that afternoon, and persuaded his father to have the operation performed, which they accordingly did without my being informed of it. I said "I understand, then, that your father is now in Dr. S.'s care?" He said he did not know anything about it any further than that Drs. S. and B. had called and performed the operation. I said I would call as arranged about 9 p.m. to make arrangements to see the patient, along with Drs. Barber and Spencer, at 11 a.m. the next day. While sitting in the back parlour Dr. S. came in, and Mrs. D. informed him that I wished him to meet Dr. Barber. He came into the room where I was, rather excited, and asked me why I did not mention in the morning that I wished to have a stranger. I said that as the patient was under my care I considered that I had a perfect right to suggest any man I wished. After a good deal of unpleasantness he said that I had no right to come about his patients, and that he would not meet Dr. Barber or any other man. Now, sir, I would ask your readers if they consider the conduct of Dr. S. justifiable under these circumstances towards me, and do they consider any action of mine unprofessional towards him?

I am, etc.,

WILLIAM FINLAY, M.D.,
 Cooper Medical College,
 U.S.A.

Bathurst, Aug. 6, 1887.

NOTE ON DRUMINI CHLORIDUM.

(To the Editor *Australasian Medical Gazette*.)

A SHORT time ago I had occasion to treat a severe case of sciatica. Having had a little drumine chloride on a filter paper I scraped it off, dissolved it in water, and then filtered it. I injected min. x of solution, and in half-an-hour 3 i. of solution (strength unknown, as the powder was mixed with filter paper, it was weak, but it paralysed sense of taste on tongue). There was soon great relief, and ease of movement replaced the previous stiff back, so that he walked easily down stairs in an hour, when the jarring of ordinary walking formerly gave him much pain. No local or other after effects appeared, although the powdered drug was over six months old. In time it will reach the market.

JOHN REID, M.D., M.A.

Melbourne, August 1, 1887.

DRUMINE.

(To the Editor of the *A.M.G.*)

SIR,—The profession is anxious, the wholesale houses of the continent and other parts indicate a certain amount of impatience in their desire to have the above drug in the market. Such is the opinion forced upon me by letters received. The wet season, however, has prevented the plant from appearing in its usual amount.

To pass from the plant to its after treatment, I would point out to those engaged in its manufacture that oxalate of lime, which is abundant in the plant, can with difficulty, if at all, be filtered; and so is best got rid of by subsidence in the neutral solution obtained by evaporating off the excess of hydrochloric acid, or from the solution in acetic acid. It may be useful to know that most of the oxalate of lime and little or none of the alkaloid is removed by a preliminary treatment of the plant for 24 hours in a cold solution of dilute hydrochloric acid. Refer back to my original paper and the tincture with methylated spirit is arrived at. The oxalate of lime is entirely insoluble in spirit, and so this process or the other may be used. In any case, in order to thoroughly exhaust the plant, much treatment, carefully applied, is called for. The acetate, in a neutral solution, causes a precipitate in phospho-molybdic acid. This test has been held over as the wholesale houses could not supply the reagent, and I deferred its preparation—a not uncommon practice among people generally, I fear.

Replying to criticisms, the strictures of the *Therapeutic Gazette* bear their own confutation. The reactions published with the phospho-molybdic will probably satisfy most reasonable minds that drumine is an alkaloid.

I trust that chemists will excuse the lengthy description of a method well known to them of eliminating oxalate of lime. The market will soon be supplied, and so the profession will be in a position to test the accuracy of my statements regarding drumine.

JOHN REID, M.A., M.D.

Melbourne, October 3, 1887.

REVIEWS.

ELEMENTARY MICROSCOPICAL TECHNOLOGY.

A MANUAL FOR STUDENTS OF MICROSCOPY. IN THREE PARTS. PART I.—THE TECHNICAL HISTORY OF A SLIDE, FROM THE CRUDE MATERIALS TO THE FINISHED MOUNT. BY FRANK L. JAMES, PH.D., M.D., PRESIDENT ST. LOUIS SOCIETY OF MICROSCOPISTS. St. Louis: Medical and Surgical Journal Company, 1887.

MICROSCOPY, like other kindred sciences, is fast acquiring an extensive and valuable literature of its own. Of late years contributions of increasing merit have emanated from most scientific countries clearly demonstrating the facts that the study of the microscope and its application to medicine and other sciences are becoming more universally known and utilised. Knowing well the very valuable aid which this instrument has afforded to the advance of scientific research in past times, we can confidently expect a greater and more rapid advance as its use becomes more general and better understood. The much greater prominence now given to microscopy in the curriculum of the leading scientific institutions and schools will, we trust, do much to popularise its use.

To the beginner in microscopical technology, especially one compelled to work apart from a skilled master, the selection of a suitable text-book is an all important proceeding. Recognising the difficulties of a student so situated, the author of this present volume has endeavoured to place before his readers a short manual essentially practical in its nature and comprising a description of the various manipulations and processes necessary in the preparation of objects for microscopical examination. In the first chapter the various processes through which the object has to pass are named in order, the instruments, apparatus and chemicals required in the manipulations are briefly enumerated, and formulæ for the preparation of a few of the best and most commonly used preservative fluids are given. The next chapter deals with the preparation of a suppositious mount, describing simply and clearly every step through which the supposed object (a tumour) undergoes after its removal from the body until it forms a finished mount. This chapter contains a great many valuable practical hints to the beginner. The author then describes in the same clear and simple style the various processes of hardening and softening tissues, embedding, section-cutting, staining, mounting, &c. The formulæ and mode of preparation and employment of the various staining and mounting fluids are given, as well as a description of some of the most approved microtomes.

Altogether we must congratulate Dr. James on having given us a practical elementary text-book, free from the complicated and lengthy descriptions so common in similar treatises, and which are so discouraging to the student. We can recommend it to the consideration of teachers and students, and look forward with pleasure to the publication of the two remaining volumes.

THE NEW ZEALAND MEDICAL JOURNAL.

WE have received the first number of the first volume of the *New Zealand Medical Journal*, edited by Dr. D. Colquhoun, and published by J. Wilkie and Co., in Dunedin. The periodical in question is to be published quarterly, under the auspices of the Otago Branch of the New Zealand Medical Association; the other branches of the Association, thinking the enterprise premature, declining to commit themselves to it. The first number before us is in form of a pamphlet, consisting of 64 pages, and containing seventeen interesting articles contributed by ten well-known practitioners of Dunedin. Amongst these are "Lupus Vulgaris," by Dr. R. Gordon Macdonald; "Successful Case of Supra-Vaginal Amputation of the Uterus and Ovaries," by Dr. H. W. Maunsell; "Case of Extra Uterine Fœtation," by Dr. F. C. Batchelor; "Case of Hysteria," by Dr. W. Lamb; "The Hall Poisoning Case," by Dr. F. Ogston; "Two Cases of Distention of the Frontal Sinus," by Dr. H. L. Ferguson; "Abscess in Right Broad Ligament," by Dr. I. De Zouche. We have looked in vain for editorials on current topics, Hospital and University intelligence, reports of societies, vital statistics, local news, and all the other usual adjuncts indispensable to a medical newspaper proper, and considering that all the articles are written by gentlemen residing in or around Dunedin, we think the title is rather a misnomer; in our opinion "The Otago Medical Record" would have been more appropriate.

We cannot conclude our notice without taking exception to some of the statements contained in the "Introductory." The editor says, "It is an undertaking of some moment to send cases to Australian journals, and comparatively few records of our experience are ever sent to Australian journals." Surely it is just as much trouble to any practitioner residing out of Dunedin to forward an article to Dunedin as it is to send it to Sydney; the only difference is that in the latter case papers are published not merely for local edification, but they are read by practitioners in all parts of the civilized world. We think it hardly necessary to point out to our readers the

fallacy of the latter part of the above statement, as they are well aware that every year we publish a large number of papers contributed by medical men practising in every part of both islands, and amongst these contributions from New Zealand practitioners we can claim the "valuable paper contributed some years ago to one of the Australian journals with reference to typhoid fever on the West Coast," referred to in the Introductory to the *New Zealand Medical Journal*.

TREATMENT OF DISEASE IN CHILDREN.

BY ANGEL MONEY, M.D., M.R.C.P., ASSISTANT PHYSICIAN TO THE HOSPITAL FOR SICK CHILDREN, AND TO THE VICTORIA PARK CHEST HOSPITAL. London: H. K. Lewis, 1887.

THIS is a capital book, and will amply repay a careful study. As the works of this series purport to be, it is thoroughly practical, and deals chiefly with the treatment of the diseases of children. To the young practitioner, and especially to those inexperienced in the ways of children, it cannot be too strongly recommended. The minutest details in the management of infant life are closely attended to. If it be a condescension to enumerate these minor matters, which conduce so greatly to the health and happiness of early years, our author deserves our hearty thanks for descending to tell us so much that is useful and necessary, otherwise only to be learned after patient observation and long experience. Hygiene, that most powerful and potent of all our weapons in the struggle against disease, receives a prominent place, and its importance repeatedly impressed on the reader. The author is dogmatic, and insists on his own methods of treatment, but with laudable catholicity gives those of others who have left their individualism to the literature of the diseases of infancy and childhood. In fact, so easy is his familiarity with the whole range of drugs, that were it not for his predilection, the reader would merely be embarrassed by the maze of remedies. The *nimia diligentia medici* is a tempting error. The danger we hint at may be inferred from a glance at the chapter on the treatment of whooping cough. There is an obtrusive affection for stimulants leavening the pages; "old brandy," "high-class port," "sound wine," "good port," "hot grog," evidently occupy a fixed place in the author's category of remedies.

A word as to style. The diction throughout is polished, and evidences taste and care. At times it becomes pedantic, and obviously strained for

effect. "Pyrexia profoundly perturbs the physico-chemical processes of the protoplasm" is not bad, but alliteration is weak in prose. But these are small things. The book is so full of sound teaching that it cannot fail to prove one of the most useful of this praiseworthy series. To the family physician it will prove a correct guide to what is latest and best in the therapeutic agencies at our command. We congratulate Dr. Money most warmly on this useful and altogether elegant addition to our literature.

BURROUGHS & WELLCOME'S EXHIBITS AT THE INTERCOLONIAL MEDICAL CONGRESS IN ADELAIDE.

AMONGST other items of interest at the Intercolonial Medical Congress, held at Adelaide, was an exhibit of the advancements in Pharmacy, manufactured by Messrs. Burroughs, Wellcome & Co., of London, whose representative was present, and ready to supply any information concerning them, as also literature and specimen cases, to members of the Congress free of cost. Amongst the many articles of interest exhibited were the new "Valoids," or equivalent fluid extracts, so regulated in strength that one minim of the Valoid represented one grain of the drug. Nearly every root and bark in general use is now made in this new form. The Valoid of Ergot and Cascara-Sagrada having been made a specialty of in regard to quality and price. The new Voice-tabloid, containing chlorate of potash, borax and cocaine, was also exhibited, as also specimens of the Strophanthus in the pod form, as well as in tincture and tabloids. A new Cod Liver Oil brought out by this firm, shewn and known as the "Kepler" Cod Liver Oil, appeared to be very fine in quality and nearly tasteless; this same oil is now mixed with the Kepler Malt Extract, and so intimately is its mixture that no traces of the oil was witnessed under a half-inch objective. Amongst the new drugs in "Tabloid" form was Antipyrin, Tri-Nitrite—the new name for nitro-glycerine,—Tri-Nitrite, with Nitrate of Amyl, Capsicum and Menthol, Urethane, &c. Specimens of the digestive ferments, as manufactured by the "Fairchild" process, including Zymine, Peptonising Powders, Pepsin in Scales, and the Tabloid form of these ferments, were all exhibited, and specimens freely given away. A few bottles of the new "tryptic ferment" known as "Trypsin" was shewn, but beyond some remarks made upon it by Dr. Barrett, in the August number of this journal, very little is known of its action; in it is the first preparation of "trypsin" ever offered in this market. There was a great variety of pocket, buggy and hypodermic cases, which were elegantly got-up. A new hypodermic case, containing a silver syringe, needles, with pencil and place for notes, about 3 x 1 inches and 1/4-inch in thickness, and containing 12 tubes of hypodermic tabloids, struck us as being a very useful companion for a medical man in cases of emergency.

Messrs. Burroughs, Wellcome & Co. have opened offices in Melbourne, now in Chancery Lane, where they keep full stocks of their preparations, and we are informed by their representative that at all times they are willing to give specimen cases of their preparations to medical men upon request, and for hospitals will supply any reasonable quantity of their articles free of cost, to admit of a thorough test being made.

THE INSANE POPULATION OF QUEENSLAND.

FROM the annual report of Dr. Scholes, Inspector of Asylums for the Insane in Queensland, we learn that on December 31, 1886, there were 811 patients—387 males and 306 females in Goodna, and 118 males in Sandy Gallop, Ipswich. During the year there had been 989 persons under treatment—612 males and 377 females; 115 were discharged, 61 died, 2 absconded and were not recovered and 205 new patients were admitted; therefore the increase over the previous year was 27. The daily average number of patients in the two asylums was 789—487 males and 302 females. The asylums were greatly overcrowded during the year, but this evil will shortly be remedied, as a new ward is in course of erection at Goodna, and a new asylum at Toowoomba is also being built. The proportion of lunatics to every 1000 of the general population is 2·4 per 1000 in Queensland, 2·63 in New South Wales, 2·7 in New Zealand, and 3·27 in Victoria. In Scotland the proportion is 2·38, and in England and Wales 2·87 per 1000. The natives of the whole of Australia contribute only 0·49 per 1000 inmates, while the proportion of Queenslanders is 0·35 per 1000. The death-rate was higher last year than it had been since 1874—being 7·73 per cent. of the inmates in the former and 7·95 per cent. in the latter year. The cost of maintenance of the asylums at Goodna and Ipswich last year was £23,329 14s. 1d., or £29 11s. 4½d. per head—taking the daily average at 789. £253 15s. 6d. was collected by the sale of asylum produce, and £1,318 8s. 2d. was received by the curator in insanity for maintenance of patients, so that the actual cost to the State for lunatics was £27 14s. 0½d. The annual cost per inmate has decreased from £33 8s. 8½d. in 1881 to £27 14s. 0½d. in 1886. Dr. Scholes draws special attention to the large number of lunatics who are sent to the asylums within a brief period after their arrival in the colony. 14 per cent. of all the admissions in 1886, and 13·5 per cent. in 1885 were recent arrivals, and many of these had been insane previously to being sent out to Queensland.

UNIVERSITY INTELLIGENCE.

A CONFERENCE took place on September 26, between the Melbourne University Council and the Faculty of Medicine, as to the best method of providing for the instruction of lady medical students. The Faculty thought it was highly undesirable to give more than one course of lectures, and that there would be no difficulty in the ladies attending those classes along with the male students. A serious difficulty, however, was in clinical teaching, as it would be undesirable to have male and female students together at such a time. The council will carefully consider the subject at the next meeting.

MR. T. N. FITZGERALD, F.R.C.S.I., has written to the Council of the Melbourne University, stating that he would allow his salary to lapse as lecturer in clinical surgery, and would not accept further appointment unless clinical lecturers were placed on the same footing as the other lecturers in the medical school. He explained that under the circumstances he could not retain the office, but in order that the students might not be inconvenienced he was willing to continue to perform his duties till the end of the July term.

OBITUARY.

GEORGE LAWRENCE MARSHALL LLOYD-APJOHN.

WE regret to have to announce the death of George Lawrence Marshall Lloyd-Apjohn, B.A., M.B. et Ch.B. Trin. C., Dub., 1882, Medical Officer of the Springsure (Qu.) Hospital, who died of consumption, on September 14, while on his way to Rockhampton by train to seek medical advice; the deceased gentleman was at one time Resident Surgeon at the Sydney Infirmary.

HENRY DILLON CROKER.

We have also to record the death of Henry Dillon Croker, M.R.C.S. Eng., 1837, who died at Beaufort (Vic.), on September 9, after a short but painful illness, at the ripe age of 73. The deceased had been 34 years in the colony, 20 of which he had spent in the Beaufort district. He was part proprietor of the first stone-crushing machine which arrived in the colony, and which was used to crush the ballast for the Geelong and Ballarat line; he had also been a mining speculator on a large scale. He was a justice of the peace, holding a direct commission from the Queen, and a surgeon on the unattached list of the Victorian militia force.

SOLOMON IFFLA.

Another old colonist and practitioner, Solomon Iffla, L.F.P.S. Glas., 1844, died at Parliamentary-place, East Melbourne, on September 14, at the age of 66 years; formerly he practised for many years at South Melbourne.

JAMES MARKEY.

It is our painful duty to record the death of James Markey, L.R.C.S. Irel., 1864, L.R.C.P. Edin., 1865, who died at his residence, 12 Regent-street, Sydney, on October 5; the deceased gentleman was a native of Rockbellew, Co. Meath, Ireland; on his arrival in the colony, just 22 years ago, he commenced practice in the Richmond River District, he then came to Sydney and became House Surgeon in the Sydney Infirmary, and finally settled down at Redfern.

ROBERT STEWART.

ROBERT STEWART, L. et L. Mid., R.C.P. et R.C.S. Edin., 1866, for many years Health Officer and Public Vaccinator at Smythesdale (Vic.), is dead.

MEDICAL APPOINTMENTS.

- Bett, James Wilson, M.B. et Ch.M. Aberd., to be Public Vaccinator for Merino and Digby, Vic.
 Bonrobier, Joseph Gabbett, M.D., to be Government Medical Officer and Vaccinator for the district of Tumberumba, N.S.W.
 Ounninghame, John, M.B. et Ch.M. Edin., to be Public Vaccinator for the district of Blueskin, N.Z.
 Davenport, Arthur Frederick, M.B. Lond., M.R.C.S.E., to be Public Vaccinator for St. Kilda West, Vic., vice Dr. W. B. Rankin, resigned.
 Hayes, James Bennett, L.R.C.P. et R.C.S. Edin., to be Public Vaccinator for Smythesdale, Vic.
 Lindsay, Peter Alexander, elected Resident Medical Officer at the Provincial Hospital, Auckland, N.Z.
 Pardey, Charles William, M.B. et Ch.B., Melb., to be Health Officer for the district of Swan Hill, Vic.
 Smith, Edward Roberts, M.R.C.S.E., to be Government Medical Officer and Vaccinator for the district of Cowra, N.S.W.

THE MONTH.

NEW SOUTH WALES.

THE Legislative Council, on September 21, re-appointed the Select Committee to inquire into the state and operation of the laws now existing for the regulation of the practice of medicine and surgery in New South Wales.

MARY YOUNG, commonly known as "Dr." Mary Young, was charged on remand at the Central Police Court, Sydney, on September 22, with performing an unlawful operation; and Elizabeth Morales, better known as Madame Sibley, with having been accessory before the fact. It appeared from the evidence that the former practised as a specialist, and the latter as a fortune teller. On August 27 Elizabeth Dunstan, wife of John Dunstan, of South Melbourne, who was on a visit to Sydney, went to Madame Sibley, who recommended her to consult "Dr." Mary Young, who operated on her. Mrs. Dunstan became dangerously ill, and is still in delicate health. In Young's house were found several drugs used for improper purposes, and this prisoner stated to Mrs. Dunstan that she had other cases under treatment, and had successfully operated on hundreds of persons. The prisoners were committed for trial, bail being allowed.

DR. J. BRUCE, late of Richmond, has removed to Murrumburrah, in a pastoral and agricultural district, 230 miles S. of Sydney.

DR. E. L. GUYENOT, late of the Glebe, Sydney, has removed to Richmond, on the Hawkesbury River, 38 miles N.W. of Sydney.

DR. D. S. MCCOLL has commenced practice at Bathurst, in conjunction with Dr. W. Finlay.

DR. M. MATHESON, formerly of Aramac (Qu.), has settled at Waverley, a suburb four miles from Sydney.

DR. E. G. TENNANT, late of Parramatta, and formerly of Dubbo, has commenced practice at Forbes.

DR. G. VANZETTI, of Albion Park, and formerly of Nymagee, has removed to Forbes, the centre of a large pastoral district, 250 miles W. of Sydney.

NEW ZEALAND.

A COMPANY has been formed, with a capital of £5,000, for the purpose of establishing a sanatorium at Te Aroha Hot Springs (Prov. Auckland), which are famed for their remarkable efficacy in the treatment and cure of rheumatic, gouty, cutaneous and other affections. The appointment of Dr. Alfred Wright as honorary physician to the baths has just been confirmed by the Government.

In the Supreme Court at Dunedin, on August 31, an application was made for a nonsuit in the case of Sutherland v. Dr. A. H. Neill. The plaintiff had been an attendant at the Seacliffe Asylum, and he brought an action against Dr. Neill, the Medical Superintendent of the Asylum, for libel, and a verdict was given for £5. The nonsuit was moved for on the ground that libel was not proved, and if it was that it was privileged. Judgment was reserved.

Nor less than three patients died at the Wellington Lunatic Asylum on September 3.

WE are informed that the first death at the Waikato Hospital occurred on August 27, due, as is alleged, to the want of the necessary surgical instruments, which were not to be procured in

the colony, but which Dr. Kenny had ordered from home. We can hardly believe this statement to be true, considering that any instruments which may have been required could have been obtained within a week, on forwarding a telegraphic order for them, either to Mr. L. Bruck, in Sydney, or Messrs. Mayer and Meltzer, in Melbourne. The patient eventually should have been sent by rail to the Provincial Hospital in Auckland, where the necessary operation, no doubt, could have been performed.

DR. THOMAS L. BANCROFT, son of Dr. Jos. Bancroft, of Brisbane, has been elected to the position of House Surgeon at the Christchurch Hospital, in the place of Dr. Guy D. Porter, resigned.

DR. J. GUTHRIE, of Christchurch, has been elected president of the newly formed "Canterbury Anglers' Society."

DR. W. MURCH, of Hamilton (Waikato) met with a double buggy accident on September 20, but we are glad to hear that he escaped without being hurt in any way.

NORTHERN TERRITORY.

NOTWITHSTANDING that Dr. P. M. Wood, the Govt. Health Officer at Port Darwin, has condemned Goat Island as being utterly unsuitable for a quarantine station, the Government intend to call for tenders for the erection of a station there. The Chairman of the Local Board of Health at Palmerston has severed his connection with that body owing to the Board's recommendations being disregarded by the Government, and their requests being ignored.

THE Local Board of Health at Palmerston (Port Darwin) has condemned not less than seventy-six bark huts, occupied by Chinese, as being unfit for human habitation.

QUEENSLAND.

THE Blackall Hospital authorities have reduced the charge to paying patients from 30s. to £1 per week.

DR. H. J. HEWER, of Barcaldine, has taken charge of the Aramac Hospital.

DR. M. E. FITZGERALD, late Acting Medical Officer of the Aramac Hospital, and formerly of Charters Towers, has secured the appointment of Surgeon to the Springsure Hospital, rendered vacant by the death of Dr. Lloyd-Apjohn.

DR. H. C. BRANNIGAN, of Aramac, has removed to Rockhampton, where he has been appointed Resident Surgeon of the Port Curtis and Leichhardt District Hospital.

SOUTH AUSTRALIA.

A DEPUTATION representing the Social Purity Society was introduced to the Governor on September 28, and presented a petition, to be forwarded to the Queen, in opposition to the Contagious Diseases Act, asking Her Majesty to use her influence to bring about the abolition of those laws throughout her dominions.

At the annual meeting of the St. John's Ambulance Association, held at Adelaide on September 29, a satisfactory report was presented, showing that the association had been very successful since its establishment, nearly three years ago. The Governor presided, and presented a number of certificates to those who had passed the examinations.

A LADIES' class of St. John's Ambulance Association, under Dr. Dunlop, is in progress at Glenelg, and men's "first-aid" classes at Riverton, Glenelg, and several of the suburbs of Adelaide. A sub-centre is about being formed at Gawler.

SEVEN members of the Tanunda Ambulance Society, instituted and conducted by Dr. Altmann, received certificates of competency on September 21.

WE sincerely regret to hear that Dr. Verco, of Adelaide, the president of the late Intercolonial Medical Congress, is suffering from inflammation of the brain. Though improving, his condition is critical.

TASMANIA.

THE want of lymph in Tasmania for vaccination purposes having been notified to the Central Board of Victoria, a supply of 500 points of calf, and 100 points of humanised lymph was forwarded by the a.s. Flinders on September 26, to the house surgeon of the Launceston Hospital, for distribution among the public vaccinators. Dr. Haines, of Longford, who, being on a visit to Victoria, and was returning to Tasmania, also obtained a quantity of lymph for the use of vaccinators at the north-west ports.

VICTORIA.

THE question of the validity of the vaccination certificates given on behalf of Mr. Graham Mitchell as to the children whom he vaccinates with calf lymph, came before the Supreme Court in Melbourne on September 12. As we foreshadowed in our editorial in the June number of the *A. M. G.*, the Court was of opinion that the certificate was sufficient, and gave their decision in favour of Mr. Graham Mitchell, with costs against the prosecutors.

DR. J. B. HAYES has settled at Smythesdale, the centre of a large mining district, 115 miles W. of Melbourne.

DR. C. J. RUTLEDGE, a new arrival, has commenced practice at Warrnambool.

DR. E. G. FIGG, Government Health Officer at Williamstown, has been suspended by the Central Board of Health for permitting a passenger from Launceston to land at Williamstown, contrary to the direct orders of the Board.

DR. G. BIRNEY, of Drouin, has removed to Jumbunna East, in South Gippsland, 90 miles E. of Melbourne.

PUBLIC HEALTH AND SANITARY NOTES.

At a conference on federal questions, between Sir Henry Parkes, Premier of New South Wales, and the members of the Victorian Ministry, held in Melbourne on September 12, one of the questions dealt with was the proposal to establish federal quarantine stations off the first ports of call. The Government of Western Australia has objected to a quarantine station being located within its jurisdiction; but it is thought to be probable that arrangements can be made for federal quarantine stations at two places on the Australian coast. Before any definite action is taken in the matter the other colonies will be communicated with.

THE question of federal quarantine will be considered at a conference of the presidents of the Central Boards of Health of the various colonies, to be held shortly.

All the colonies except New Zealand have replied expressing their acquiescence in the proposal to hold a conference, and it will probably be held either at Sydney or Melbourne.

THE Chief Secretary of South Australia, on the recommendation of the S. A. Central Board of Health, has communicated with the Hongkong Government, to ascertain, first, whether it will insist on ships leaving there with immigrants for Australia carrying a duly qualified medical practitioner; and, secondly, whether it will take measures to prevent Chinese embarking for Australia without a certificate of recent successful vaccination from the Hongkong health authorities.

FOUR cows, kept at a dairy at Redfern (Sydney), were found, on September 29, to be suffering from pleuro-pneumonia. One of them, being in the last stage of the disease, was ordered to be killed.

SMALLPOX has broken out at Launceston. There were twenty-two cases altogether up to October 8, three of which have terminated fatally.

AN extraordinary epidemic of measles has broken out among the children attending the school at Manningtree road, Hawthorn, a suburb of Melbourne. The usual number of scholars is about 700, and of these no less than 200 are now suffering from measles. The school board has decided upon closing the school for a short time.

THREE State schools have been closed in Collingwood (Melbourne) owing to the prevalence of measles. A large number of children in that suburban city are suffering from the complaint.

AN epidemic of measles was raging at Westport (Province Nelson) last month.

SCARLET fever was very prevalent at Beachport (S.A.) about the beginning of last month.

TWO cases of scarlet fever in one family have been reported from Millicent (S.A.), the centre of a wheat-growing district, 252 miles S.E. of Adelaide.

DURING the week ending October 1, nine cases of diphtheria, of which seven proved fatal, were reported to the Central Board of Health of Victoria, also three cases of typhoid fever, one being fatal.

HOSPITAL INTELLIGENCE.

THE Board of Management of the Alfred Hospital, Melbourne, have appointed a sub-committee, consisting of Messrs. Ellery and Thomson, for the purpose of framing the rules for the new clinical school attached to the institution.

NOTICES of operations at the Alfred Hospital, Melbourne, are to be posted at the Melbourne University, for the convenience of the medical students.

THE board of management of the Prince Alfred Hospital (Sydney) having acquiesced in the resolution passed by the Senate of the University, on August 15, relative to a medical tutor, applications for the position have now been invited.

THE adjourned meeting of the benefactors and subscribers to the Sydney Hospital for Sick Children was held at the board-room of the Liverpool, London, and Globe Insurance Company, Sydney, on September 26, for the purpose of hearing the result of the ballot which had been taken with a view to confirming or otherwise the action of the Board in dismissing Miss Holden, the lady superintendent. The chair was

occupied by Mr. J. S. Mitchell, and there was a good attendance. The motion submitted adverse to the board was in the following terms: "That the benefactors and subscribers to the institution, from their knowledge of the lady superintendent, and of her useful work at the hospital, are of opinion that the board were not justified in summarily dismissing her from her position." Against this there had been an amendment, "That the board has the confidence and support of the subscribers." The result of the ballot which had been taken was announced as follows: For the resolution, 19 voters, having 39 votes; for the amendment, 63 voters, having 118 votes; majority in favour of the amendment, 79 votes.

AT a meeting of the Board of Directors of the Sydney Hospital, held on October 4, a letter was received from Dr. Muskett, the secretary of the honorary medical staff, stating that the honorary medical staff approved of the proposed regulations with regard to a course of instruction to the nursing staff, and at the same time were of opinion that before any certificate to a nurse should be granted, the recipient should have attended a course of instruction, passed an examination therein, and have remained for a period of not less than two years in the hospital. The regulations suggested by the medical staff were approved of, with the proviso that they should not be retrospective, as it was considered that a hardship might be inflicted on some of the nurses who had been for some time at the hospital if they were compelled to attend the lectures and pass the examinations.

A HOSPITAL is to be erected at Croydon, an important gold-fields town in Northern Queensland.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Harwood, Septimus, M.B. Edin., 1881.
Smith, Ventry Alexander John, L.R.C.S. Irel., 1881; L. & L. Mid., 1884; K.Q. Coll. Phys. Irel.
Simmons, Fourness Henry, M.B. Edin., 1884; M.S. Edin., 1884.
Baxland, Walter, F., 1886, M., 1888, R.C.S.E.; L.R.C.P. Lond., 1884.

TASMANIA.

Percival, Montague William Cairns, L. & L. Mid., 1877, M., 1883 K.Q.C.P. Irel.

VICTORIA.

Richards, William Nicholas, M.R.C.S. Eng., 1838.
Wright, Thomas Cole, M.B. & Ch.M. Edin., 1868.
McGea, William, L.R.C.S. Irel., 1883; L. & L. Mid. K.Q.C.P. Irel., 1883.
Rutledge, Charles James, L.R.C.S. Irel., 1886.

Additional qualification registered:—

William L. Mullen, South Melbourne, Ch.B. Melb., 1887.

MR. BRUCK, medical bookseller, of Sydney, desires us to state that he has received a full supply of Jonathan Hutchinson's new work on Syphilis, with 8 coloured plates; also of the new editions of Fothergill's Practitioner's Handbook of Therapeutics, and Druitt's Surgeons' Vade-Mecum; Bristowe's Theory and Practice of Medicine, 6th ed. (1887); Lennox Browne, The Throat and its Diseases, 2nd ed. (1887); Crookshank, Photography of Bacteria (1887); Fothergill, Manual of Dietetics (1887), and many others.

REPORTED MORTALITY FOR THE MONTH OF AUGUST, 1887.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Group and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Bronchitis.	Pneumonia.
N. S. WALES.														
Sydney	135,000	368	150	46	...	1	2	...	4	1	27	10	8	10
Suburbs	200,000	864	213	88	...	2	6	3	2	4	19	20	11	12
NEW ZEALAND.														
Auckland	35,965	106	33	11	...	1	...	1	...	1	2	4	8	1
Christchurch	15,684	32	13	6	...	...	1	1	...	...	2	4	...	1
Dunedin	24,233	56	32	10	...	...	1	...	...	1	4	3	1	1
Wellington	26,956	90	39	16	...	...	...	...	1	1	5	2	4	2
QUEENSLAND.														
Brisbane	32,571	139	36	17	} ...	...	7	1	1	2	7	8	2	10
Suburbs	41,082	166	57	24										
SOUTH AUSTRALIA.														
Adelaide	309,372	1,046	266	70	...	1	6	1	5	2	36	22	13	12
Adelaide	42,904	94	69	8	...	...	1	...	2	...	12	5	1	3
TASMANIA.														
Hobart	31,116	91	25	6	...	...	...	...	4	1	6	5	1	2
Launceston	19,490	75	22	8	...	...	...	...	1	1	6	3	1	1
Hospitals, Asylums, Gaols, &c. .	1,325	...	40	...	...	...	...	...	...	...	...	...	...	...
Country Districts.....	89,080	251	75	...	...	...	8	...	1	5	...	...	...	...
VICTORIA.														
Melbourne	69,774	217	118	} 233	14	2	15	4	9	11	73	59	56	50
Suburbs	275,606	1,213	538											

METEOROLOGICAL OBSERVATIONS FOR AUGUST, 1887.

STATIONS.	THERMOMETER.				Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.		Depth.	Days.		
Adelaide—Lat. 34° 55' 33" S. ; Long. 138° 36' E.....	...	76.5	53.7	36.6	30.059	Inches	...	...	...
Auckland—Lat. 36° 50' 1" S. ; Long. 174° 49' 2" E.....	121.1	61.1	49.6	35.1	...	1.390	14	77	...
Brisbane—Lat. 27° 28' 3" S. ; Long. 153° 16' 15" E.	127.6	69.5	59.3	51.1	30.198	11.796	19	74	w.
Christchurch—Lat. 43° 32' 16" S. ; Long. 172° 38' 59" E.....	122.2	67.4	44.5	27.4	...	2.550	12	77	...
Dunedin—Lat. 45° 52' 11" S. ; Long. 170° 31' 11" E.....	...	...	...	...	...	...	...	...	...
Hobart—Lat. 42° 53' 32" S. ; Long. 147° 22' 20" E.....	...	69.8	49.5	33.1	30.125	1.58	12	84	...
Launceston—Lat. 41° 30' S. ; Long. 147° 14' E.....	...	68.1	47.3	29.1	30.170	1.06	10	82	...
Melbourne—Lat. 37° 49' 54" S. ; Long. 144° 58' 42" E. ....	...	72.1	50.4	33.6	30.125	0.96	11	...	...
Sydney—Lat. 33° 51' 41" S. ; Long. 151° 11' 49" E. ....	...	66.1	54.8	42.5	30.216	7.33	17	77	w.
Wellington—Lat. 41° 16' 25" S. ; Long. 174° 47' 25" E.....	117.1	60.5	46.1	31.1	...	9.270	15	73	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

ON TRACHEOTOMY.

READ BEFORE THE N. S. WALES BRANCH, B.M.A.

BY R. SCOT-SKIRVING, M.B., ASSISTANT PHYSICIAN TO THE PRINCE ALFRED HOSPITAL, HONORARY PHYSICIAN TO THE CHILDREN'S HOSPITAL.

In a society such as this it seems desirable that every-day subjects should be discussed, as well as those which are new and strange; and with this view I would introduce the subject of tracheotomy, more especially in its connection with diphtheria. It is never pleasant to tell of personal ill-success,

and I do so now because I believe that the very pardonable habit of publishing successes oftener than failures is not seldom a hindrance to the proper appreciation of the dangers or value of any special operation or plan of treatment, and hence those who run do not always read aright the real teaching of general experience. I propose, therefore, to give a brief account of my own experience of this operation in different conditions, but mainly in acute disease. During the last few years I have had occasion to open the windpipe on more than twenty occasions, the necessity for the operation having been called for by a variety of ailments, the greater number being those of acute disease causing suffocation. It would be wearisome to go *seriatim* into the history of these cases, so I have tabulated 20 in the table in your hands. The cases of special interest I will advert to as may seem desirable.

TABLE OF CASES OF TRACHEOTOMY.

Case.	Age.	Disease.	Anæsthetic.	Result.	Remarks.—Cause of Death, &c.
1	47	Epithelioma of Larynx	Chloroform	Recovery	Gave great relief. Endo-laryngeal operation subsequently performed.
2	5	Papillomata of Larynx	Do.	Do.	Endo-laryngeal operation performed subsequently.
3	36	Phthisis Laryngea	None	Death on 2nd day	Trachea opened when patient was almost in <i>articulo mortis</i> ; immediate relief of asphyxic condition.
4	38	Syphilitic ulceration and Perichondritis	Chloroform	Recovery	Great benefit.
5	42	Aortic Aneurism	Do.	Death on 5th day	Operation relieved the suffocative spasm; patient died of pneumonia.
*6	4	Diphtheria	Do.	Death on table	Case far gone. I believe anæsthetic turned the scale.
*7	2½	Do.	Do.	Death about 4th day	Pneumonia followed.
*8	9	Do.	None	Death on 2nd day	Double pneumonia followed.
*9	5	Do.	Chloroform	Death	Disease extended into bronchi.
*10	4½	Do.	Do.	Death on 5th day	Patient suddenly collapsed.
*11	6	Do.	Do.	Death on 10th day	Secondary hæmorrhage and asthenia; used the thermo-cautery.
12	5	Do.	None	Death	Bronchitis (?)
13	2	Do.	Chloroform	Death on table	Had pneumonia when seen; anæsthetic precipitated the fatal result.
14	1½	Do.	Do.	Death on 1st day	Had pneumonia when seen; a case of great urgency; had a long journey.
15	4	Do.	None	Death on 3rd day	Great urgency; very severe hæmorrhage at operation; pneumonia subsequently.
16	6	Do.	Chloroform	Death on 5th day	Died of asthenia.
17	3	Do.	Do.	Death on 2nd day	Bad nursing—tube became plugged.
18	5	Do.	Do.	Death on 4th day	Disease extended down trachea.
19	3½	Do.	Do.	Recovery	Severe hæmorrhage at operation; artificial respiration; tube removed finally on 12th day.
20	4	Do.	Do.	Death on 14th day	Operation done early; secondary hæmorrhage on 8th and 9th days; vomiting; death by asthenia.

* In these cases the ages of the patients and the days of death are approximate figures.

About the first five cases I have little to say. In chronic laryngeal disease tracheotomy is often of great value, and not valued sufficiently as a form of treatment. Not only may it relieve the pressing necessity for air, or avoid the possibility of such a condition occurring, but it gives the diseased parts physiological rest, it renders easier endo-laryngeal treatment, "topical applications can be made from below, and by means of the better oxygenation of the blood the whole system is put in better condition."—(Spence.) My individual experience of the operation under chronic conditions, as you see, is small, but in the practice of those whose opportunities have been wider, I have constantly been struck with the great benefit to be derived from a performance of tracheotomy. In the few cases I have thus treated this view has been borne out. In case I., of epithelioma, I was easily able, after tracheotomy, to remove, endo-laryngeally, a necrosed arytenoid cartilage, and the patient experienced a marked diminution of suffering. In case II. the operation was of distinct service in apparently checking the rapid growth of warts, and rendering easy their partial removal. In the case of syphilitic disease, the ulcerative process seemed to be arrested after the windpipe was opened, and I am inclined to attribute largely the good result in this case to the operation. In the cases of phthisis laryngea, and aortic aneurism, causing suffocation, I cannot regret the operation, as it secured to the patients at least a fairly comfortable death. With these few remarks on chronic conditions I will pass on to the consideration of cases of an acute disease, such as diphtheria.

At this point I may allude, for a moment, to the oft-disputed point of the identity or non-identity of croup and diphtheria. For myself, it was taught that these were two diseases, and many points of diagnostic difference were given between them. A now fairly large experience has driven me to a disbelief in the practical value of these distinctions. I do not enter into the question of whether a membranous exudation, other than diphtheritic, is possible in the air-passage. I would here simply state my clinical belief, first, that all inflammations accompanied by a true membranous exudation, whether in the larynx or pharynx, should, at the bed-side, be regarded as diphtheritic. Secondly, that the term croup is, or ought to be, considered a symptom of obstructed breathing, and not a disease.

For purposes of discussion it will be well to consider certain definite points. First, when is the operation to be done, and shall we use an anæsthetic? Secondly, the technique of the operation and the after-treatment. Lastly, to what causes are due the great mortality of these cases?

To the first question I think most of us will answer "whenever pressing symptoms of obstructed breathing supervene." Now in non-diphtheritic conditions, such as œdema glottis, simple laryngitis, I think one is justified in waiting a little before operating—recession of the chest-walls may be pretty well marked, and yet the urgent symptoms may suddenly cease, and the patient go on to recovery without the added risk of a tracheal opening. In diphtheria, however, I think the case far otherwise. There I have again and again satisfied myself that, in the vast majority of cases, once laryngeal symptoms occur they progressively increase in gravity till asphyxia supervenes. I would not, indeed, suggest so early a tracheotomy as to forestall all laryngeal obstruction, and so perhaps make a patient with a mild attack bear the additional risk of a tracheal wound; but I would urge the earlier recourse to operation in cases where any true symptoms of obstruction are present. When there is evidence of membrane in the larynx, and the patient has had the benefit of ordinary treatment, there should, I think, be no further delay—operate forthwith.

Now what constitutes a bar to the operation? Does pneumonia? Does bronchitis, or great weakness and lividity from non-aeration? I think not. Truly the first condition, and probably the second also, in spite of a great opinion to the contrary, make the prognosis of the case much graver. Still, how can we refuse to give relief to any case, however bad, even if death occur on the table. I hold that humanity and good practice tell us, that if we cannot save life by tracheotomy, we can at least give the patient an easier death.

I believe that in almost all cases an anæsthetic, preferably chloroform, should be given, the exceptional cases being where the state of weakness is so great that the additional depressant action of the chloroform might fatally turn the scale. I think that two of my fatal cases were injuriously prejudiced by the anæsthetic. In cases of great urgency of course one operates without delay, but in these cases the asphyxic condition carries with it an insensibility to pain.

As regards the operation itself I am sure it is best to employ the high operation. In a fat child, with a short neck, an opening below the isthmus leads one on a deeply-placed trachea, and unpleasantly near the sternal notch; moreover, the greater nearness to the seat of the disease in the high operation does not really count for much against it. After the skin incision is made and the linear interval between the muscles recognised, the dissection is perhaps best conducted with two pairs of dissecting forceps. I have once used the thermo-

cautery at this stage—I shall not do so again. If the isthmus is seen it can be pulled downwards; but if this is difficult, or the moment is critical, I have never seen any bleeding to signify if it were wounded. Points of the last importance are fixing the trachea before opening it, and avoidance of wounding any vessel in the act of opening it. To do the former, a sharp hook should be firmly inserted into the windpipe, and to avoid the latter the tracheal rings should be very bare before they are cut. This cut should be made from below, upwards, with a little plunge. The wound now becomes filled with blood-stained, frothy mucus, and it is well to pause, and keeping the wound open, to allow time for the ejection of membrane. One is usually in too great a hurry to get in the tube at this moment. Artificial respiration at this juncture may be called for—success following. The tube just now may be one whose outer part is bi-valve; this is more easily introduced than the round-ended kind, which might miss the trachea altogether.

The after-treatment I have adopted has been as follows:—After the child has been put into the cot, the steam of a kettle of water, medicated with eucalyptus, is turned just to the entrance of the curtains, but not near the wound. I believe I have seen harm done by turning the cot into a vapour bath. On a few occasions I have omitted the steam, but I now feel sure that a degree of warm moisture renders the patient more comfortable and the air less irritating, and more like that which, under normal conditions, has been warmed by contact with the upper respiratory mucosa.

After the first forty-eight hours are passed I take out the outer tube and put, usually, in one of a more rectangular shape than the ordinary quarter circle tubes. Parker's or Durham's, fitted with a moveable collar, seem less likely to cause ulceration than any others. I have used vulcanite which can be bent and cut to the required size. The outer tube I take out for cleansing purposes every twenty-four hours during the time it is worn. The wound I wash with Condy's fluid, or sublimate solution, and then dust with iodoform. After the first few days I cease to use the inner tube at all. The tube which is worn towards the end of the case should have an opening to allow some air to pass through the larynx.

I feed by the mouth if I can, but by the rectum if needed, making great efforts to get the patient to take nourishment freely, and usually stimulants as well.

No rule can ever be made as to when to do without the tube. After the fourth day I begin to make efforts to dispense with it. I put an oiled silk valve over its orifice, and remove it for a lengthening period during the days. It has

frequently to be kept in at night for a considerable time after it has been done without during the day.

The general treatment goes on. If I can, without an exhausting fight with the child, I treat the local expression of the disease in the fauces with appropriate remedies. I am satisfied that the more of the membrane which can be removed, the less the likelihood of the child dying of the intensity of the poison. Iron, and chlorate of potash internally, and carbolic acid or lactic acid as a spray, seem to be our most useful drugs. I wonder how papaine would answer as a solvent of the membrane.

Lastly, why are these cases so fatal? Diphtheria, outside its mechanical danger of causing suffocation, is a very lethal malady by reason of its proneness to cause death by septicæmia, broncho-pneumonia, or cardiac paralysis, or, finally death by asthenia. In addition to this we have the fact that in the majority of cases operation is delayed till far too late to save life, till broncho-pneumonia and an asphyxial condition are present. Moreover, the after-treatment, which has so great an influence on a favourable result, is not seldom inefficient. In the houses of the poor, dirt, carelessness, and the giving of inadequate nourishment, lead to sepsis; to accidents with the canula, to extension of the membrane and avoidable failure of the vital powers.

Gentlemen, I have done. I leave many points untouched, but I have detained you too long as it is. In conclusion, however, I must allow myself to say that, disheartening as my record is, I shall go on performing the operation, even in the most hopeless conditions; firstly, because an occasional success makes up for many failures; and also because even where the operation is not likely to gain credit, at least it renders death easier.

CASE OF HYDATIDS IN BONE.

By CHARLES GEORGE LEACOCK, M.R.C.S.E.,
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The above being a somewhat rare disease of bone, I think the case may be of sufficient interest to the profession to justify its publication. Mr. C., æt. 40, has had trouble on and off with his left knee since he was twelve years old, when he received a blow from a cricket ball. This disabled the limb for some time, but he ultimately recovered the full use of the joint. About twenty years ago he was kicked by a horse on the same knee. From this he says he never quite recovered, the joint being always weak, slightly swollen, and at times painful. Some thirteen years later, consequent on a good deal of walking and a possible sprain, these symptoms were so

much aggravated as to necessitate medical treatment, which was continued for six months, the patient being more or less confined to bed during that time. Since then—that is for the last seven years—there has been inability to completely straighten the limb, frequent pain, and permanent though slight enlargement of the joint. The patient came under my care about four months ago, through having struck the knee violently against a post. I saw him a couple of hours after the accident, when he was suffering very acute pain in the joint. This was relieved for the time by a hypodermic of morphia, but returned on the effect of the drug passing off. For a fortnight he kept his bed, with all the usual local symptoms of acute synovitis, but little or no constitutional disturbance or rise of temperature. At the end of that time, the pain having greatly subsided, he left his bed on crutches, but could not put his foot to the ground, and the pain gradually returning, after two or three weeks he was compelled to take to bed again. All the usual means for obtaining absolute rest to the joint were adopted. Extension, which usually gives relief in acute joint disease, in this case seemed only to increase the pain. There were no symptoms, either local or general, of suppuration. There was only a slight increase of swelling about the knee; very little effusion in the joint, the permanent seat of pain being referred more particularly to a spot on the inner condyle of the femur. In addition, there were the usual electric shock pains and startings, aggravated at night.

Finding, after about a month's treatment, that absolutely no improvement took place; that the patient's health was beginning to break down from constant pain, and that he himself was anxious for relief at any risk, I suggested resection, or amputation if found necessary. This was willingly assented to. Accordingly, on the 25th June, assisted by Dr. Wiston Baker, of Lambton, and Dr. Donovan, of Sydney, Dr. Beattie, of Camden, kindly giving chloroform, I proceeded to operate. On opening the joint, we found a small amount of flocculent lymph, slight erosion of the articular cartilages, and on digital examination a perforation admitting the tip of the finger, between the condyles of the femur, apparently communicating with a cavity in the end of that bone. There was chronic thickening of the ligaments and fibrous tissue of the joint, but no pus; nor did we see any hydatid cysts in the joint, and we were certainly not expecting them. On applying the saw to the condyles of the femur, the instrument did not meet with the usual resistance; the bone in fact was a mere shell, in some parts scarcely thicker than paper. Such being the state of affairs

amputation was the only resource. This I at once did in the lower third of the thigh.

On examining the removed limb, the lower end of the femur was found hollowed out into one large cavity, stuffed full of hydatid cysts, from the size of a small pea to nearly an inch in diameter. The cancellous structure in the head of the tibia was undergoing fatty degeneration, and in the popliteal space was an ounce or more of broken down soft tissue, evidently a commencing abscess, though not yet converted into pus.

The stump healed almost entirely by first intention.

Apart from the rareness of hydatids in bone, the interest of the case, I think, mainly consists in the inquiry as to how long they had been there, and whether injuries to the knee affected their activity in any way, so as to lead to an increase of production, and consequent inflammatory action. A correct diagnosis, I think, could only be arrived at by trephining the bone at the seat of pain.

Camden, September 16, 1887.

ON A SIMPLE FORM OF GALVANO-METER, SUITABLE FOR MEDICAL USE.—[ILLUSTRATED.]

By GEORGE T. HANKINS, M.R.C.S.E., HONORARY SURGEON, ROYAL PRINCE ALFRED HOSPITAL, SYDNEY.

AFTER reading recent accounts of the electrolytic treatment of uterine fibroids and of strictures of the urethra, I was impressed with the necessity of procuring a galvanometer capable of measuring the currents used in such cases. As no instrument suitable for the purpose could be found in the city, I consulted Professor Threlfall of the Sydney University, who most kindly entered into the matter, and suggested a plan by which I could myself make such an instrument as I required.

The conditions to be fulfilled were these:

The indications must be on such a scale as to be easily referred to during an operation, without the operator changing his position; the indicator must be fairly steady; and the instrument capable of indicating from 1 to 250 milliamperes of current.

Portability was considered so to complicate matters that it was left out of the question for the present: besides, it would require for its attainment the aid of a watchmaker or skilled workman.

In order to meet the first and second requirements, it was considered that a galvanometer on the "dead beat" or "mirror" plan of Sir William Thompson, would be most suitable, and

that the third would be met by dividing the coil into two halves, and suspending the needle between them, when different strengths could be given to the instrument by approximating the coils to, or withdrawing them from, the centre; also, when any high currents were used, by removing one of the coils altogether.

Acting on these suggestions, I made many tentative experiments, and found that for such currents as we require, a sufficiently sensitive instrument could be constructed with one coil, made moveable, so that its distance from the magnetic needle could be altered at will.

I will first give a description of the instrument, and then go on to explain how to calibrate it, or give a value to each deflection of the needle.

A coil of fine cotton-covered wire, No. 36 gauge, is wound round a cardboard cylinder, with a calibre of one inch. The total diameter of the coil when wound is two and a half inches, and its thickness one inch. To attain the size, about 1,600 turns of wire are necessary. The coil is then soaked in melted paraffin in order that the insulation of the wire may be perfect, and when cold its resistance is measured by means of a Wheatstone's bridge; but, as so much depends on the accuracy of the measurement, I should advise any novice getting this little matter done for him by an expert. The coil is now fixed upright by means of melted paraffin in a square box (a Higginson's syringe box cut in half is what I used), and the ends of the wire attached to two screw terminals on the sides of the box, by which they are joined up in circuit when required.

The next step is to arrange the needle and mirror. To do this I use another syringe box, uncut, and stand it on end, remove the sliding lid, and into the back of the box (in its present position) fix near the top a wooden peg. From this peg, by means of a single fibre of silk, suspend a slip of cartridge paper, an inch wide and five inches long. At a spot on the paper corresponding with the centre of the upper half of the box, gum a piece of thin flat looking-glass, about half-inch square. And on the same slip, at a spot corresponding to the centre of the lower half of the box, gum transversely a piece of flattened watch spring, an inch long, which has been magnetised in the usual way. We now have a magnetic needle and mirror on the same plane, one moving with the other, and suspended by a fibre of silk from the top of the box. At a spot on the box lid, opposite the mirror, cut a circular hole and fit in a spectacle lens of about 30-inch focus. The box should be raised on four little blocks of wood, half an inch thick, attached to it as feet, to allow a

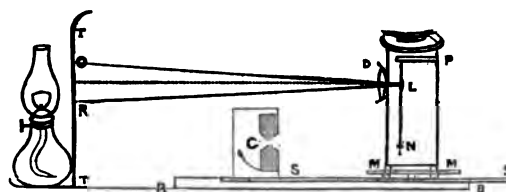
permanent magnet (made of a steel rod, five inches long and quarter inch cross section,) to be placed underneath it, immediately below the magnetic needle, so that the latter can be controlled and made to a great extent independent of the earth's magnetism.

A wooden base board is now provided, eighteen inches long, six wide, and one in thickness. At one end of this is placed the box containing the magnetic needle and mirror—the lens looking towards the opposite end. In front of this is stood the box containing the coil, in such a position that the lumen of the coil looks towards the magnetic needle, the height of the latter being regulated by turning the peg, so that it is exactly on a level with the centre of the coil.

Some simple mechanical arrangement will now permit of the coil being approximated to, or withdrawn from, the needle, without removing the latter from the line of axis of the coil.

The next step is to make a screen by bending a blackened sheet of tin plate, so that it will stand upright, facing the mirror and lens. At a point opposite the lens, but at a level about half an inch below it, a vertical slit, three-quarter-inch long, is cut in the tin screen, and immediately above the slit is pasted a paper scale, divided into centimetres, extending horizontally the whole length of the screen.

The division immediately over the slit is marked 0, the graduation extending from the centre to each extremity, and ranging from 1 to 25 or 26 on each side. A small paraffin lamp is stood behind, so that its flame, placed edgewise, corresponds with the slit in the screen. The distance between the lens and screen should always be the same for the same instrument—in this case 30 inches.



C Coil fixed vertically on box attached to slide S
SS Slide, working in a groove in base-board B
L Mirror } Both suspended by fibre of silk from
N Magnetised needle } peg P
M Permanent magnet moving on pivot, for regulating needle
TT Tin screen, with slit at R for transmitting ray of light to L,
from which it is reflected on to scale at O
D Convex lens for focussing light spot on screen.

The apparatus, now finished, should be placed on a firm shelf fixed to the wall, to avoid vibration. The lamp being lighted, the directing magnet beneath the box is so manipulated that the mirror reflects the ray of light coming through the slit on to the scale at zero. If now a current from a battery is sent through the coil, the spot

of light will be deflected to the right or to the left, according to the direction of the current, and the deflection will moreover be in proportion to the strength of the current.

In order to make the indications on the scale absolute, and not merely relative, it is necessary to calibrate the galvanometer in the following manner:—Couple up with the instrument a Daniel's cell, in which the zinc rod is immersed in a saturated solution of sulphate of zinc, the copper plate being as usual in a saturated solution of sulphate of copper, separated from the zinc solution by a porous cell. Thus arranged, the cell has a known electro-motive force of .98 volts.

In order to arrive at the current, the E.M. force of the cell is divided by the resistance of the circuit, according to Ohm's law. The only resistance in the circuit in this case is that of the galvanometer, which has been ascertained. Suppose this resistance to be 296 ohms, the current would be given thus— $\frac{.98}{296} = .0033$ ampere, or $3\frac{3}{10}$ milliamperes. Whilst this current is flowing, adjust the distance of the coil from the needle, so that the light spot settles at 3.3 on the scale, and mark with a pencil the position which the coil occupies on the base board. Each division on the scale now equals one milliampere, and the galvanometer, as adjusted, will indicate up to 25 m. a. If we wish to use a higher current than this, we must adopt the following plan:—Couple up a sufficient number of cells of any battery to produce a deflection of 20 centimetres, or 20 milliamperes, now push back the coil from the needle whilst the current is still flowing, until the light spot settles at 2 c.m. As you still have a current flowing of 20 m.a., it is evident that each centimetre on the scale must now equal 10 m.a. In other words the "constant" of the galvanometer is now 10, whilst in the first instance it was 1. In this position of the coil, the instrument will indicate up to 250 m.a., which is as much as is usually required.

In case it should be required to set up the apparatus in some position other than that in which it was calibrated, it will become necessary to test it again with the Daniel's cell, and readjust it if necessary, on account of the varying effect of the earth's magnetism in different positions, or of the possible presence of masses of iron in its neighbourhood, which, being unsuspected, would have a disturbing influence on the magnetic needle.

The apparatus I have attempted to describe is, of course, capable of much elaboration, but my efforts have been directed towards keeping its construction as simple as possible. The principle being understood, the details may be varied according to the ingenuity of the maker.

SMALL-POX AND QUARANTINE.

By J. ASHBURTON THOMPSON, M.D., BRUX.;
DIPL. PUBLIC HEALTH, CAMB.; CHIEF
MEDICAL INSPECTOR OF THE BOARD OF
HEALTH, N.S.W.

(THE following is the second part of a paper read before the Sanitary section of the Royal Society of New South Wales on October 18. In the first part the history of the voyage of the s.s. "Port Victor," which began at Hongkong on May 24, was told, and reasons for concluding that 16 Chinamen carried by her are the last persons known to have reached Launceston by an infected vessel were given):—

I venture to ask your attention a few minutes longer while I make some general remarks upon quarantine as against small-pox. They are rendered necessary, I believe, by a tendency at present perceptible to rely upon that measure for more protection than it can possibly yield; but I do not propose now to say very much, because, whatever my opinions may be worth, I have at all events made them known in various publications during the past five years.

I must remind you first that the subject is pre-eminently technical in this sense, that it can be examined profitably only in the light of that practical experience which the records of civilised countries, during several centuries past, afford. The promises of quarantine are fair and full; and at the first blush, or even after study, seem easy of performance; but tested by the event they are found to be pretentious, and a snare to those who trust them unreservedly. To demonstrate this from the source alluded to would be easy, but it could scarcely be done within reasonable space; it is moreover unnecessary, for the experience of our own country and of our own age suffices.

I will next quote the 4th resolution of the Australasian Sanitary Conference of Sydney, 1884, "Vessels infected with small-pox are those which have carried a case of that disease during the voyage," and I point out that the restrictions of ancient quarantine were thus excluded by the Conference from applying to vessels which merely hailed from an infected port. The Delegates who deliberately and unanimously affirmed this proposition were (myself excepted) the principal medical officers of the seven Governments represented; and these gentlemen had for years been practically engaged in restraining the entrance of sea-borne disease by quarantine. It is a fair assumption that they knew at least as much of the subject as others know. Nevertheless it seems that now, in the face of some danger from Tasmania, more than one of the Governments,

then represented by their most experienced officers, are unwilling to act upon the conviction so clearly expressed by the latter, and actually have reverted to the practice of ancient quarantine by applying the law to merely suspected vessels hailing thence. Upon this point I do not intend to argue farther. It is judged by implication in the course of the following remarks, upon the ground of present practical experience, and I do not think that anyone who takes the trouble to consider them seriously will maintain that that reversion is wise, or at all likely to be useful.

Thirdly, as to the powers and limitations of quarantine, I have defined both in the following sentence, "The true function of quarantine is not to prevent the entrance of contagion, but to limit the entering number of sources of contagion." This proposition is indisputable in the face of experience, and quite recent events here can be adduced to prove it. As to the first part the very case of the "Port Victor" to which you have just listened shows that occasionally circumstances arise in which it is practically impossible to detect contagion until it has effected entrance and is active among the shore population; while, as for the second part, the experience of the current year alone in the cases of the "Preussen," the "Chingtu," and the "Tsinan," proves that it is, as far as it goes, a most useful and an indispensable defence. But what quarantine can do must not be considered alone. It concerns not individual, but national interests, and the price to be paid in the doing must not be left unbalanced against the benefits purchased in exchange. Even the limited quarantine I have just described cannot be used without entailing serious expenditure both on the country maintaining it and, what is not a widely different interest, upon ship-owners; for persons arriving by an infected ship cannot be ascertained to be themselves free from infection by any examination which does not involve detention during considerable periods. Nevertheless, expensive as it is, I would not willingly see the least relaxation in its severity while our circumstances remain what they now are, for I believe that it affords a fully equivalent measure of security. Herein, it may be observed, our practice differs from that of the English. But this should not sway us to give up our plan, because there is a sound reason for it which consists in circumstances which the English do not feel. This also I have formulated; the whole case is stated in the phrase, "Nations whose internal sanitation is defective cannot afford to refer the observation of suspects to the country at large."

The foregoing are general considerations; but in the present case of Tasmania there are some of

a more special nature to be entertained. The very foundation of the labours of the Conference was frank recognition of the unity of Australasia as regards disease; recognition of the fact that, for all practical purposes, the infection of one territory must be taken to imply the infection of all. It was clearly seen and admitted that inter-colonial quarantine is a farce long since played out, and it was on that very ground, and on no other that Tasmania was invited to join in the scheme of federal quarantine outposts from which so much is hoped, and which is indeed capable of conferring great benefits. That admission, I am satisfied was wise, for I see that it is enforced by the unfailing argument of experience; but the reason may be given in yet a third proposition, the truth of which is self-evident, "The protection afforded by quarantine is inversely as the ease of communication between the country infected and the country to be defended."

But what, then, is to be said of the attempt which has been made on the first appearance of danger to enforce that ruinous delusion, ancient quarantine, against an island which politically should be, and physically is, a dependency of the colony making it? Its sole justification would appear to be the possibility of effectually preventing all communication by means of it. But is this possible, even theoretically? A fatal flaw appears at first sight. At all events quarantine cannot be enforced until the supposed necessity for it is known to exist, and that is not until a case of the disease feared has been discovered. But how often is the first case observed, the first case that occurred? Very seldom indeed, as we know well, and as has now happened again in Tasmania; so that the infection may have already been exported before any interruption of communication is attempted. However, Tasmania is a small island, so that if communication ever can be entirely suspended it should be easy in her case; yet what are the facts? Why, that quarantine has been twice broken within the past few days—I speak of known instances merely—and two persons at least have landed, even at Melbourne itself, from two separate vessels. It does not matter at all by what accident they came to land; they succeeded in evading the defence of quarantine, and were arrested on shore. Now, observe, the question is not one concerning contraband of trade. A cargo may occasionally be run in spite of the most active coast-guard service, no doubt, but the loss to revenue is measurable, for it cannot exceed the capacity of the vessel; and once in a way, the smugglers may be made welcome to what they have cunningly snatched. But quarantine tries to deal with a body which has powers of self-multiplication; so that the smallest

boat that holds a man may as seriously threaten the importing country as the Orizaba or the Ormuz. But, it may be said, if quarantine cannot entirely prevent communication, at all events half a loaf is better than no bread; and so it is—when you can get it. The implied statement would seem to be that the chance of importing disease increases proportionately with the number of persons introduced. But this obviously is not true unless all are equally susceptible in the first place, and in the second have all been equally exposed to infection; and this is never the case. But, farther, the element of human nature must not be left out of account. In the present case, a man living in Hobart and under necessity to reach the mainland might very probably sail in the usual way trusting to the supposed cleanness of that city to escape arrest, and so would fall under detention on arrival; but a man who lived in Launceston, knowing that he could not escape detention, nor yet, perhaps, afford to suffer it, would be likely to seek some irregular means of transit. He could easily escape the quarantine officers; and yet he would be one of the very persons it is most desirable to exclude. This illustration is not fanciful or rhetorical, but on the contrary represents universal experience; and the opinion is warranted that the more urgent the danger from infection, and the more stringent the measures taken under ancient quarantine to exclude it, the greater in reality becomes the likelihood that the latter will be evaded and the disease introduced; while the more quarantine is relied upon to entirely exclude infection, the more are other and truer and better measures of defence likely to be overlooked.

I have hitherto spoken designedly, not of epidemic disease, but of contagion. To some casual local spread of contagious disease two conditions alone are necessary, that, namely, of the presence of the specific contagion, and that of local and personal susceptibility. Against epidemics thus arising our limited quarantine (I speak now of shore populations) or policy of isolation of whole households, is probably a sufficient defence usually. But to pandemic extensions of disease, and probably, therefore, also to any very wide and uncontrollable local spread, a third condition seems necessary. What this is is not yet known, its presence may be inferred from the observation that whereas diseases liable to pandemic extension are endemic in many localities yet they become formidable and almost universal only at particular times. Now if such accessions of virulence were merely local, they might perhaps be accounted for by accumulation of susceptible persons, newly born for the most part since the last preceding outbreak, when the then

susceptible either got immunity after suffering or were killed off. But it is not in isolated spots that such accessions are observed as a rule; on the contrary many widely separated places begin to suffer about the same time, and hence it must be concluded that a third condition is necessary to and is the cause of them. This being so, if we have hitherto escaped any very serious epidemic of small-pox, clearly that is because the presence of the unknown condition has not hitherto coincided with that of the other two. For on the one hand we constantly exhibit a full measure of personal susceptibility, since, as I have calculated, there are in Sydney alone at least 100,000 unvaccinated persons, reckoning those only who are under 20 years of age; and the specific contagion has been introduced here many times, and must continue to be introduced from time to time in the future, notwithstanding the greatest possible watchfulness at quarantine, and notwithstanding the arrest of all but a very few undiscoverable cases. The small outbreak of 1881 seems to me a conspicuous example of the absence of the third condition; for although there were then in the city (as I reckon) about 23,400 unvaccinated children under five years of age alone, and although the contagion remained alive and active for about eight months, yet no more than 154 persons suffered out of a population of 228,000. Compare this with the case of the city of Montreal in the fall of 1885, when no less than 2,500 persons lay sick on a single day, and where the total deaths amounted to more than a thousand. No one, I think, can doubt that there something more than mere breakdown of measures of isolation was at work. I make these remarks because I no longer care to share in the administration of a scheme of defence against this disease which I see is valued by the public far beyond its true worth, without stating my opinion that useful as it is, and necessary to be retained, it is yet not to be trusted to prevent the spread of a true epidemic. When the three conditions happen to coincide here we shall suffer even as Montreal did, and as a thousand other cities have done; and it is scarcely doubtful that then the public will blame the administration of the Health Department. But I declare beforehand that that blame will be unmerited unless the Department shall have connived at neglect of what is the only protection against small-pox worth attention I mean vaccination. However, successive Chiefs of that Department have again and again urged it; and, for the twentieth time perhaps, I disclaim any such connivance, and I venture to do this not less for the profession of this city as a whole, than for myself individually. The Government cannot

enforce vaccination since it is believed (I know not how reasonably) that the public will have none of it; but when the time of epidemic comes, as soon or late it must come, it will be the people who will suffer and not the doctors or their families.

A CASE OF ACUTE YELLOW ATROPHY OF THE LIVER.

READ BEFORE THE SOUTH AUSTRALIAN BRANCH, B.M.A.

BY PROFESSOR WATSON AND DR GARDNER.*

L.O. æt. 19 years, native of New South Wales, admitted to Adelaide Hospital 29th September, 1887.

On admission there were several sores about the left labium and fourchette, said to be of one month's duration. She was deeply jaundiced, and through the yellow tint a distinct secondary syphilitic rash was visible.

Three weeks before admission to the Hospital she felt "sick and giddy," and jaundice appeared.

On October 2 she became collapsed with sordes on teeth and tongue—pupils dilated.

October 3.—Loss of power in the hands noted, and faltering speech.

October 4.—There was difficulty in swallowing, dilated pupils, Cheyne-Stokes' breathing.

October 5.—Up to this date she was treated by the House-Surgeon for cerebral syphilis.

On October 5 first seen by Dr. Gardner, who, after examination, found the liver-dulness to be only 1½ ins. vertically; and this, with the peculiar cerebral symptoms, led me to a diagnosis of acute atrophy of the liver. Up to this date the temperature remained normal.

October 7.—T. 100·2.

October 8.—T. 103; pupils widely dilated. In the evening they became contracted, but acted to light.

October 9.—T., M. 100·4; T., E. 103·5.

October 10.—Died at 6 a.m.

Dr. Poulton, who had seen the patient previous to admission, stated that he had attended her for an abortion.

Post-mortem on the 10th October, nine hours after death:—

Slightly emaciated female body; general icterus; scalp recently shaved (for pediculi);

raised scabs up to a quarter of an inch in diameter on scalp; purpuric stain over dorsum of right foot; three fresh scars of recent multiple chancres.

INTERNAL EXAMINATION.—*Abdomen*: Multiple hæmorrhagic staining of great omentum and mesentery, more especially around unenlarged mesenteric glands. Similar hæmorrhagic staining (to a less extent) of parietal peritoneum. Intestine empty, except scybalous masses in great intestine. *Stomach* contained some charcoal-like fluid. The sub-mucosa showed multiple punctiform extravasations. *Liver* weighed half an ounce under two pounds—i.e., half its normal weight. Its appearance was remarkable, the bulk of the right lobe and the whole of the lobus spigelii being of a bright yellow colour. The left lobe and the whole of the anterior border of the liver was of a dark red colour, and over the red part the capsule was thrown into small wrinkles. There were several other islands of yellow appearance, slightly raised from surrounding red tissue, and varying from a hazelnut to a walnut in size.

Gall-bladder, nearly empty; it contains a few drops of light amber-coloured fluid.

Kidneys were slightly enlarged—right 5½ oz., and left 6 oz. The pyramidal part was of a dark red colour.

Spleen weighed ½ lb.; rather firm, and of a very dark colour.

Bladder semi-distended, with bile-stained urine, which was drawn off and subjected to chemical analysis by Mr Turner, of the University, and found to contain a large quantity of leucine and tyrosine (specimens shown).

Thorax—*Lungs* remarkably free from pigment; the lower part of the right showed extensive non-infarctic hæmorrhages (specimen, microscopic, and parts shown). Left lung showed two or three faint patches.

Heart, pale and flabby; not enlarged; contained no clots, but some fluid blood.

Head.—General oozing of surface of dura mater on skull-cap; no thrombi in any of the sinuses; blood everywhere liquid.

The *Brain* showed no actual hæmorrhages, but was congested, giving a punctiform oozing in all parts on section. Slight excess of fluid in ventricles; choroidal plexuses stained a bright saffron colour. *Bucco Pharynx* free from ulceration. *Thyroid Glands* a little enlarged, tense and yellow, and semi-transparent, like a piece of raw bees-wax.

Remarks.—Owing to a change in house-surgery, Dr. Gardner did not see this patient, who was in the Magdalene Ward, until October 5,

* Professor Watson supplies the pathological notes, and Dr. Gardner the clinical remarks in each case.

and this mistake led to an imperfect observation of the case. The fact that she had aborted, and was also suffering from syphilis, is in harmony with the conditions observable in most of the reported cases of atrophy of the liver.

ENCEPHALOID SARCOMA OF FRONT OF ELBOW, SIMULATING ANEURISM.

BY PROF. WATSON AND DR. GARDNER,
ADELAIDE.

P. L. æt. 17, was admitted to the Adelaide Hospital for the third time in August, 1887, and for the history we are indebted to Mr. Lynch, medical student:—The patient, a lad now 17 years of age, affirms that immediately after having received a sharp blow in front of the right elbow-joint, he noticed a swelling which slowly increased. His medical adviser, believing it to be a traumatic aneurism, tied what was held to be the brachial artery in the middle of the forearm. The swelling did not decrease in size as a consequence of the operation, and in July, 1886, it suddenly became so swollen that the patient consulted Dr. Gardner, who found a fluctuating swelling in front of the elbow, with pulsation communicated to it by two large arteries stretched across it superficially. These were recognized as the radial and ulnar arteries arising from a high division of the brachial.

On August 4, 1886, the tumour was cut into and the contents of the cavity evacuated, which was composed entirely of soft non-laminated blood-clot. Hæmorrhage was stilled by plugging the cavity with carbolized gauze, which was withdrawn the next day, and the wound healing kindly the patient was discharged. Six months later the patient returned with the swelling in the same state as before, when a similar operation, followed by apparently as good a result, was performed. Another six months elapsed and the patient returned with the tumour as big as a man's fist, irregular and lumpy in its outline, with paroxysmal pain from stretching of the median nerve.

On July 20, 1887, Dr. Gardner ligatured both the radial and ulnar arteries in the middle of the arm through separate incisions, one to the outer side and the other to the inner side of the original ligature of April, 1886, by Dr. Comyn. Pulsation at the wrist, which ceased immediately on application of the ligatures, returned on the tenth day.

On August 4, 1887, one year after the first evacuation, the sac was incised and emptied for the third time. The wound did not heal and occasional lumps of foetid clot and fluid blood were discharged.

On September 28, at Dr. Gardner's suggestion, Dr. Giles amputated the arm through the middle of the humerus.

The tumour, on dissection, was found to consist of a distinct capsule, inside of which was a vast cavity with various saccular dilatations, containing blood-stained, brain-like matter and fresh blood-clot, and was intersected by several fibrous bands. The growth was anchored at the base to the internal intermuscular septum and over its anterior surface pass the median nerve and the somewhat contracted radial and ulnar arteries—the latter, strange to say, lying external to the radial, with which it again changes place below the bend of the elbow by bending inwards and dipping downwards to its usual situation beneath the pronator radii teres muscle. At this point, in addition to the common inter-osseous artery, it supplied a median artery quite as large as itself to the forearm and palm.

Microscopically, the semi-diffusent mass was found to consist of large oval cells, with no recognisable intercellular substance.

A few days after the amputation of the arm, patient complained of pain of very severe character in the left side, and at last fluid was discovered, and on aspiration it was found to be purulent and bloody. It was aspirated a few days after and similar fluid removed. After consultation, a portion of one of the ribs was removed and a drainage tube inserted. The stump healed kindly and the discharge from the pleura is daily lessening. He has gained flesh, and is making most satisfactory progress.

This case must be added to the already long list of cases in which a mistake in diagnosis has been made between aneurism and malignant tumours which pulsate. It should have been stated that, on stethoscopic examination, no bruit could be heard. Had the contents of the tumour been examined microscopically when it was first cut into, no doubt the error would have been corrected. Those interested in the subject should read a very able paper by Mr. T. Holmes, in the 7th volume of "St. George's Hospital Reports," to which our attention has been directed by Dr. Stirling, entitled, "On Pulsating Tumours which are not Aneurismal, and on Aneurisms which are not Pulsating Tumours." It is at least some slight comfort to know that in our mistake we are in company with Ferrand, Desault, Pelletan, Dupuytren, Guthrie, Moore, Sir Jas. Paget and Pirogoff.

A CASE OF ULCERATIVE ENDOCARDITIS.

By P. T. THANE, L.R.C.P. LOND., M.R.C.S. ENG., OF YASS, N.S.W.

J. P., aged 6 years, was first seen by me on 25th July, 1887. He was a thin but otherwise healthy-looking boy, complaining of pain in the stomach and constant vomiting. His family history was good, father and mother being alive and healthy, save that the former has suffered from onychia of several fingers, which had not improved under anti-syphilitic or any treatment. He had 5 brothers and sisters alive in good health, and had lost an infant sister at the age of 9 months. He has never had any illness, except about 4 years ago, when he had a "convulsion fit," which laid him up for a week. This apparently was epileptic, as he foamed at the mouth, bit his tongue, making it bleed, and was insensible for some time. Never had any recurrence since. Otherwise his health has been very good. Never suffered from shortness of breath or cough. His father says that he has noticed his heart beat hard at times. His present illness commenced on the evening of 22nd July, when he *first* complained. He went to school that day, and up to the evening seemed in perfect health. He vomited and got very feverish, and has since kept so. From that time has kept nothing on his stomach. He complained of pain in thighs and head on that night, but they did not seem to be very severe, and now the only pain is in the pit of the stomach. Bowels open on the 22nd; he had an aperient powder last night (24th), and bowels freely opened to-day. Present state—T., 108; P., 132; R., 30. The boy has flushed cheeks and restless manner, talking foolishly at times, saying that he will fall, &c.; but answers questions quite rationally. He appears to be weak on his legs. He complains of pain in the epigastrium and of constant vomiting. He has no cough. Tongue is red, with thick yellow fur in centre; skin, hot and dry, but there is no rash visible. There is no joint affection nor any cedema of feet or legs. Pulmonary resonance is normal, breath-sounds are quite clear and natural everywhere; no adventitious sounds audible. The apex of the heart can be felt just $1\frac{1}{2}$ inches below left nipple, the beat being very marked, but the area of dulness is not enlarged. At the apex there is a loud blowing systolic murmur, and this can be heard all over the chest, back and front, and hiding the cardiac sounds. There is great hyperæsthesia of surface of abdomen, especially at the epigastrium;

no abnormal dulness; the hepatic dulness reaching to margin of ribs. On palpation he contracts the abdominal muscles very strongly; nothing abnormal to be felt. No marked distension of abdomen.

26th.—T., 102; P., 108; R., 27. Much the same. Had no sleep last night, raving all night.

27th.—T. 104; P., not countable, being small and weak. Urine—clear, acid, 1015, no albumen. Was even more delirious last night, and continually talking. There is no paralysis. He has not vomited since yesterday. Drinks milk well, but takes no other nourishment. His mother states, that for the last fourteen days he has had, on and off, a slight discharge from the left ear, thin and waxy-like. Has not had it for the last two days. He has never complained of any ear-ache.

28th.—T., 102·8; P., 120. He passed a better night, and is quieter to-day. There is marked paralysis of *right* arm: he can just lift the hand a few inches. The left side of face appears drawn slightly; he cannot raise left eyelid so high as right. Left pupil is larger than the right, but both react to light. He complains of soreness in left hand and toes of both feet. The radial side of left wrist and hand, with thumb and index finger, are swollen, motley red in patches, and very tender. On both feet, the balls of the 5th and 4th toes, with these toes, appear swollen and tender; more marked in the left, where there are red spots, somewhat raised, and feeling hard. The skin around these spots is red, giving it a mottled appearance. The left wrist has this mottled look from the presence of similar spots. There is no vomiting; bowels are freely opened. The tongue is as before.

29th.—T., 108; P., 120. Has passed a quiet night. Complains of pain being more severe in the two little toes of left foot. Cardiac murmur continues, but not quite so loud. Pulmonary signs quite normal, as before. Taking plenty of milk.

30th.—T., 102·8; P., 108.

31st.—T., 108; P., 132; smaller and weaker. Paralysis continues as before. Has raised right arm up to head (so his father states), but cannot move it at all now. On attempting to, he cries, and says it hurts him. Left eye-lids getting red and sore; always picking them. Was very delirious again last night. He complains of *very* severe pain in left small toes: here the red spots have turned quite black on the ball of the little toe and on the dorsum of the 4th toe. The swelling has gone from the right toes, and partially from left hand and fingers. Bowels very free.

Sept. 1st.—T., 102·6; P., 132. He is much

weaker ; not sensible at all. He cries constantly about pain in the left toes ; he seems to get some ease when rubbing them. He is taking less milk. Tongue very dry, and with thick fur in centre. Bowels still loose, but abdomen seems distended and hard.

2nd.—T., 108·4 ; P., 144 ; R., 60. Passed a quieter night, and is dozing now. Pain in toes seems less. He is hardly sensible ; when spoken to loudly he tries to open his eyelids. Bowels open twice. Urine clear ; no albumen. There are some fresh red, hardish spots above the remains of the swelling at the left wrist, of which there is less, and also less swelling of thumb and index finger. There are also some fresh spots about the sore toes on the left foot. About the centre of the left thigh, in front, and also about the centre of the right calf behind, there are more similar spots, dull red, raised and hardish, giving the same mottled appearance to skin. Above the left olecranon there is an ecchymosis of the skin, the size of a shilling. He has had no rigors all through his illness, and the skin to-day for the first time is moist. The paralysis is as before. Less distension of abdomen. The systolic murmur is again very loud to-day. On the ball of the great toe of the right foot is a small scabbed surface, quite healthy looking. His mother states that this was very sore a few days before he took ill, hurting him very much to walk.

3rd. Continued in the same condition to 1 a.m., when he died. No *post-mortem* examination allowed.

The chief interest in this case centres in the diagnosis, which, of course, in the absence of a *post-mortem* examination, cannot be definitely settled. I have headed it Ulcerative, or as Dr. Osler more appropriately calls it, malignant endocarditis, as that was my diagnosis. For the first four days I was undecided. Evidently the boy was suffering from some very acute febrile disease. The absence of any distinctive rash or condition of skin, excluded measles, scarlet fever, and erysipelas. Typhoid I excluded, from the sudden and severe symptoms, as one could not possibly imagine that he could be so seriously ill in four days from enteric fever. At first I was in favour of meningitis from some unknown cause, as the constant vomiting and delirium seemed to point to some cerebral mischief. And later on, when the paralysis showed itself, it seemed feasible to ascribe it to some inflammatory effusion, perhaps localised. But the condition of the left wrist and toes could not be explained by this. The discharge from the ear I felt sure was, from its character and duration, only due to catarrh of the external meatus. There was no history of any inflammation of the middle ear, leading to

ulceration and caries of the petrous bone. At first I did not attach so much importance to the cardiac condition. Here, in the bush, I have met several cases, where children have been brought to me for different ailments, and have found them suffering from cardiac mischief, which has been quite overlooked by the parents, as well as its cause. On inquiry, one learns that the children have suffered from pains in the limbs, either rheumatic or growing (as the parents often call them), and that no importance has been attached to them. So that it was not until the fourth day that I looked upon the heart as the primary organ at fault, and with this view the paralysis and the condition of the toes and wrist can be explained by emboli from the cardiac valve. To my mind it certainly seemed in this case that the acute attack was grafted on to a chronic one ; for I judge from the considerable hypertrophy of the heart that there must have existed some cardiac lesion for some time previous to this acute onset. I must admit that pyæmia, starting from the small wound on the right foot, did not occur to me. When I pointed out the spot to the boy's mother, it looked just like a small cut, scabbed over, quite healthy, and not inflamed, and till then the mother had quite forgotten to tell me about it. I fancy that it would be rather septicæmia than pyæmia, as the rigors, with sweats and abscesses, were quite absent. But of course ulcerative endocarditis is really a form of septicæmia or pyæmia, the infecting centre being the cardiac valve, instead of being some abrasion on the external surface of the body.

I am aware that one symptom is absent that is almost invariably present, and that is albuminuria ; but surely it is quite possible that emboli might pass by the kidneys. I regret that I was unable to examine the urine more frequently, but my patient was unfortunately some way out of town in the bush, and being very busy during his sickness, I could not give so much attention to him as I wished. There is yet another point that might be thought to be against my diagnosis, and that is the boy's age, he being only six years old. It is stated that there are only three or four instances on record where this disease has attacked children under ten years of age, and therefore, if my diagnosis be correct, this alone would make the case interesting.

The best account of ulcerative endocarditis that I have in my possession, is in the *Lancet* of March 7th, 1885, being the "Gulstonian Lectures" for 1885, by Dr. William Osler, of Philadelphia, and therein he states that it may occur under three conditions : "Firstly as a primary disease of the lining membrane of the heart or its valves, either attacking persons in previous good

health, or more often attacking the debilitated, or those with old valve lesions ; " and it would be under this that I would class my case.

PNEUMATIC THERAPEUTICS.

BY CHEV. V. MARANO, M.D.

IN the number of the *A.M.G.* for September, 1886, I gave a brief notice of this mode of treatment. I now purpose presenting my first clinical report of cases treated by means of compressed and rarefied air, and in doing so I wish to state : That no "hobby" has been ridden to the exclusion of other measures, the value of which has been tested by observation and experience. Dietetic, hygienic and therapeutic measures, according to recognised methods of general treatment, have been used as auxiliaries of pneumatic treatment. I leave for the reader to judge what share of the result is due to the pneumatic and what to the general measures, and whether the results obtained by the two jointly are better than those obtainable from general measures alone. In studying this method of treatment, I have done so as an observer without any preconceived ideas as to its superiority to other methods. John Hughes Bennett wrote, "that if the process employed by nature (in high altitudes) could be discovered, we might ultimately arrive at the true principle of cure." Have we this discovery in the pneumatic treatment? By means of which the following results are sought, as summarised by Dr. Jensen. 1st. The strengthening and developing of weak and poorly-expanded lungs. 2nd. The arrest of pulmonary disease in its earlier stages. 3rd. The prolongation of life, with comparative comfort, in those cases of pulmonary diseases in its later stages, where a cure is impossible.

In recording the history of each case, I have been as brief as consistent with a reasonably full appreciation of the condition of the patients. The apparatus used have been a "Waldenburg's" for expiration, only, into rarefied air, and a "Professor Sneikler's double" for inspiration of compressed air, which has generally been passed through a Woolf's flask containing *Ol. pini silvestris* or other volatile medicinal substance. Special sprays with some pulveriser or spray producer has followed the pneumatic applications whenever it has been thought necessary.

Case 5.—Mr. S., aged 37, married ; superintendent in a meat-preserving establishment, came under observation 31st January, 1887. Had never suffered from any bronchial trouble. Got wet three weeks previous to first visit, and has since

been feverish, with great difficulty of breathing, and dry, troublesome cough. Temp., 101°; pulse, 80, at 7.30 p.m. The examination revealed rales of all descriptions diffused on both lungs. Having diagnosed acute bronchitis, he was ordered to bed, and the usual general treatment prescribed. He improved considerably, and was able to resume his position on 7th February. On the 19th Feb. he presented himself to my rooms, and was hardly able to speak from dyspnoea, accompanied by great wheezing. Had been getting gradually worse since returning to his occupation, difficulty of breathing with wheezing coming on as soon as entering establishment, and getting better towards evening, after being a few hours away from it. It was now evidently a case of bronchial asthma. I used at once inspiration of strongly compressed air, with a view of forcing it into the parts of the lungs behind the stenosed places, and thus renew the arrested exchange of gases, and relieve the dyspnoea. The effect was gratifying, the mechanical treatment being fortunately well tolerated, and the patient left my room in great comfort. Being unable to attend regularly, the usual remedies were prescribed against the attacks ; but every second or third night he would call "for some air and sleep," to use his expression, which he would only get after the use of the cabinet—which was continued off and on till 21st March, when he felt quite well, and left off treatment. This spray was used while at home. *R. suc : conii 3 ij, glycerini 3 j, aquam ad. 3 ij.* Two teaspoonsful to 3 j of water for each spray. About the end of July, on his return to the establishment, from which he had been away through business for several weeks, he was seized by a new attack, of which he got well in three days, by the use of the said spray.

Case 2.—Mr. H., aged 27, single, tobacco-twister. Had suffered seven years previously from an attack of bronchitis. Sat in draught of air while wet on November 20, 1886. Was soon after seized with rheumatoid pains in right side of body exposed to draught. Called 23rd Nov., pulse, 102 ; temp., 102°. No examination of lungs made (he not complaining of any lung symptoms), a salicylate of soda mixture prescribed. On Nov. 26, P. 100 ; T. 102° ; resp. 26. Cough followed by scanty expectoration of frothy mucus—rales of different sizes, dry mostly, were diffused on right lung ; no alteration in resonance. Acute bronchitis was diagnosed, and sprays of *tr. hyoscy. et glyceri.* ordered, etc. ; progressed satisfactorily until Dec. 1, when temp. abruptly rose from 99½° to 102½° ; pulse, 100 ; with great dyspnoea. Expectoration was catarrhal and occasionally streaked with blood, and pain in right side of chest. On examina-

tion, dullness was found on small spaces of both lower lobes of lungs, more marked on right side, slight increase of vibration in thoracic walls, and not appreciable bronchophonia. Small moist rales—Catarrhal pneumonia had supervened, and it was not before Dec. 28, that he could leave his house. Dullness at basis, with fine diffused rales still persisting, compressed air was employed. Improvement was rapid, all physical symptoms and cough disappearing, and patient gaining in weight (from 8 st. 13 lbs. to 9 st. 4 lbs.) Treatment was discontinued after twelve consecutive sittings.

Case 8.—Mr. S., aged 22, single, bricklayer, came under observation March 10, 1887. No hereditary history. Two years ago had a severe cold and ever since had, with occasional periods of improvement, and sub-acute exacerbations, cough, copious mucous expectoration, streaked with blood sometimes, gradual loss of voice, being at present unable to sing. Lately had been losing in weight (from 9 st. 6 lbs. to 9 st.), and felt unable to work. Examination: Small rales at left apex, extending from middle of clavicle downwards to second intercostal space. Harsh respiration, with moist rales posteriorly on same side above the spinous process of scapula. At this same region the resonance was not so clear as on opposite side. There was no flattening of the clavicular spaces. To take the most favourable view of this case it was one of chronic bronchitis, with some inflammatory infiltration. Inspiration of compressed air and occasional expiration into rarefied air was used. Tr. cinchonæ before meals. April 16: weight, 9 st. 8½ lb., cough and expectoration completely disappeared. Rales, small, still persist anteriorly at same place. Cod-liver oil and pil. aci. arsenic. were now substituted for the tr. cinchonæ. May 6: Small rales in inspiration are still heard on very limited space, about middle of left clavicle—patient feeling perfectly well (weighing 9 st. 11 lb.), discontinues treatment. Had forty sittings in all.

Case 9.—Mr. M., 28, gentleman, married, called March 15; suffered from bronchial asthma for years past. It is generally brought on by residence near the sea-shore. He sought my advice for "something that would promote expectoration," he knowing well all the known anti-asthmatic remedies—pulse, 80; temp., 99½. The ordinary physical symptoms. Compressed air was used twice, and a spray of ammo. chlori. et vin. ipecac. several times through the day gave him great relief. On April 19, had another attack relieved by the same spray, by promoting expectoration. Mechanical treatment was not tolerated.

Case 3.—Mrs. F., æt. 22, called December 1, 1886. Pulse, 75; respiration, 20; temperature normal; weight, 7 st. 6 lb. Had an elder sister

suffering for some years from some lung affection. She herself caught cold about four years previously, had had ever since, with occasional exacerbations, dry cough; frothy expectoration; impaired appetite; attacks of hoarseness; shortness of breathing on exertion; steady loss in weight. Examination: Nutrition poor, no perceptible alteration in expansion of chest. Vesicular murmur rather harsh anteriorly on left apex. Fine crepitation in a limited spot above spinous process of scapula same side. No appreciable change in note of resonance. Catarrh of the apex-primary apyretic period of phthisis. Long sittings of the alternate application of condensed and rarefied air. To January 14, had twenty sittings, when she had gained 3 lbs. in weight, and lost the shortness of breathing. Patient never returned after this for re-examination; but informed me on August 16, that "she felt quite well and strong."

Case 4.—Mr. R., 31, fruiterer, called December 18, 1886. His mother died at 44, from lung disease; a brother has "weak lungs." About four years previously had an attack of acute bronchitis; followed since by other similar attacks, especially during winter, (last attack six months ago) which had not been followed by the usual improvement, but had been steadily getting worse. Temp., 100; P, 80-85; weight, 10 st. 5 lb. Appetite fair; sleep good; expectoration copious and catarrhal; cough worse at morning. Examination: Left clavicle prominent. Vesicular murmur harsh at left apex, anteriorly; fine rales on same side posteriorly at super-spinous and interscapular regions; expiration feeble at left basis, with occasional fine rales; percussion note dull above spinous process and voice near. Soreness on percussion under left clavicle—peri-bronchitis and inflammatory circumscribed infiltration of the lung. The non-occurrence of hæmorrhage, and then the almost complete disappearance of signs of induration did not make me inclined for tubercular infiltration. On December 18, commenced pn. treatment—and pil. acid arsenic. On January 28, 1887, cough almost gone; felt much better on the whole—weight, 10 st. 11 lbs. Physical symptoms still persisted at left apex, though not so markedly. Cod-liver oil added to previous treatment. 24th March, occasional morning cough with frothy expectoration; left clavicle still prominent; but subclavicular space expanded better; some dullness still posteriorly, but no rales—thought to have gained more in weight, but had not weighed himself. Had about thirty-five sittings. Gone on a long sea trip.

Case 13.—Miss W., aged 24, consulted me in February for some menstrual disorder. Returned on April 14, quite relieved of former

trouble, but complained of loss of appetite, lassitude, shortness of breathing on exertion, and a dry cough, at times very irritable. This, on enquiry, had existed for seven or eight months, but was thought nothing of, and attributed to the same wet feet that brought on the disorder mentioned. Temp., normal; pulse, 75; resp., 22; weight, 7 st. 2 lbs. No hereditary history. Examination: Nutrition poor, shallow thorax, with supra and infraclavicular fossæ rather depressed. Respiration weak and superficial. Vesicular murmur feeble at both apices, with some fine scattered rales, especially in expiration. Resonance and vocal fremitus normal. Premonitory period of phthisis. Pneumatic alternate treatment was commenced on 2nd May, general treatment having failed to give any relief. Had eighteen sittings by May 25; was then so much better that she almost gave up all treatment (calling four times between the said date and July 7), and only thinking "to make up for all lost dances and parties." Had six more sittings by July 20, when returned to the country. Weight, 7 st. 7 lbs. Respiration, 20. Still some rales at left apex. Ordered pil. air. arsen. Unable to take cod liver oil. Heard in September to have gained four more pounds in weight, and to progress well.

Case 1.—Mrs. V., age 29. Had had five children. Two sisters and a brother died from consumption. Commencement of her troubles dated seven years back, the monotony of the usual signs accompanying phthisis being only relieved by intercurrent attacks of acute bronchitis, etc. In August 1886, I thought her end had come—high fever, night sweats, harassing cough, etc., etc., having reduced her to death door. Relieved most urgent symptoms (fever and night sweats), directed treatment for expectoration, creasote and alcohol internally, and 2% carbolic acid spray with a Siegle's. On November 2nd had extensive consolidation of right apex, and a small cavity in left, at least one could be made out. Commenced compressed air and occasionally rarefied air. Improvement in all the symptoms soon followed, and then left for the country on December 20, after twenty-eight sittings; pulse, 75; resp., 20; weight 7 st. 12 lbs. Dullness on right side considerably less, and inspiratory and expiratory capacity much increased. Cough and expectoration almost ceased. Was delivered in June last of a strong healthy-looking boy. Suffered from congestive symptoms of the lungs about last six weeks of pregnancy. Is at present in a very low state, and will hardly recover from it. Last babe but one was very puny, and died four weeks old.

Case 15.—Mr. M., æt. 24, harness maker, single, called May 6, 1887. His mother died from some

disease of the lungs. Had never any serious illness until two months previous, when he got a very severe cough, followed by mattery expectoration, and this by hæmoptisis five weeks from commencement. Pulse, 85; temp., 101; weight, 9 st. 2½ lbs. Profuse night-sweats, no appetite, &c., &c. The right lung showed signs of extensive consolidation (dullness on percussion, strong vocal resonance, a very harsh murmur). Signs of bronchitis on left lung, great dyspnoea. Sputa copious and mattery, often tinged with blood, which sometimes was spat up pure though in small quantities. Acute consumption. Atropine was prescribed for the sweats. Compressed air and sprays of ammon., chlori. et tr. opii. Between May 6 and 29 had 18 sittings. The sputa became, after few days, frothy and lost all traces of blood. Dyspnoea considerably relieved. Treatment was discontinued through the inclemency of the weather, patient living at considerable distance from me. Heard at beginning of September that he was dying.

Case 17.—Mr. O'C., 28, farmer, single, came under examination June 18, 1887. His history was: caught a cold nearly a year ago, of which he had not only not been able to get rid of, but which was getting worse. What alarmed him this last time was the loss of his voice. At time of call he had signs of acute bronchitis, with temp. at 101, &c. The only noticeable facts were the flattening of the upper right side of the chest, and some dullness on same side. On June 23 I made him inhale compressed air, using soon after spray of amm. chlori., vin. ipeca. et tr. opii., which treatment was continued to the 28th of same month, when he would return to his country residence feeling much better. I ordered some spray and told him to be sure to write if getting any worse. Never heard up to date.

Case 10.—Miss C., 32, teacher, called March 18, 1887. No family history except that her mother has "weak lungs." Four years ago her voice commenced to give way. On examination found granular pharyngitis of the hypertrophic form and congestion of the vocal cords. Having, with topical applications, and different sprays, subdued the morbid conditions, while appropriate general treatment had been carried on all the while, and the voice not gaining much nor there being a marked improvement in her general condition, I resolved to use compressed air on April 22, with a view of removing by its pressure-action the congestion and swelling of the pharyngo-laryngeal mucous membrane, and to raise the power in her respiratory forces, the loss of which had been brought about by the habit taken of avoiding deep and vigorous breathing. Between April 21 and June 26 were taken 30 sittings; no general treat-

ment but only an occasional alkaline or sedative spray used. The effect most gratifying—the voice gaining all its strength, and the general nutrition returning as good as ever she had.

Case 14.—Miss C., 25, teacher, a sister of case 10. consulted me on April 14, 1887. The troubles with her voice had commenced 18 months previously. On examination the same morbid conditions were found, though in a lesser degree of severity than in her sister. Local and general treatment was continued to April 30, when pneumatic treatment was commenced, especially on account of limited catarrh of the apex existing. During the month of May, 19 sittings were taken, but treatment was given up in consequence of a severe cold caught through getting wet. Temporary improvement was noticeable while the treatment was carried on.

Case 7.—Miss B., age 22; called March 3, 1887. This was a case of chronic laryngopharyngitis which had commenced from an attack of laryngitis eight months previous. Had been under varied medical treatment during the said period of time. During the month of March local treatment with sprays, specially of mineral waters, and brushings was carried on with great improvement in the condition of the pharyngeal mucous membrane. But the colouration of the larynx being somewhat redder than when in health, though the natural contour of the parts was preserved, I resolved to use the pressure action of compressed air to reduce this congestion, with some tumefaction. Between April 4 and May the 7th, 21 sittings were taken, with much improvement in power of voice. Ordered change of air and rest to the vocal organs for six months.

Case 16.—Miss H., 26, housekeeper; called May 25, 1887. Enjoyed always good health till March, 1885, when she suffered from typhoid fever. Since then has had shortness of breath on exertion, with occasional cough; capricious appetite; great weakness and loss of weight, which was 10 st. before the typhoid, and which has varied since her recovery between 8 st. 12 lbs. and 9 st. 2 lbs. On examination of thorax no actual disease could be discovered, but only the vesicular murmur was feeble at basis of right lung the one most affected during the typhoid, and a shallowness in the respiratory acts. I came to the conclusion that incomplete activity of the respiratory muscles, defective expansion of the lungs, insufficient pulmonary ventilation, and, as a consequence, diminished supply of oxygen, were here at play. Patient had never got any benefit from the different modes of treatment used, excepting from change of air in the country. Between June the 3rd and August the 5th, she took about 40

sittings of compressed, alternate with rarefied air. From about July the 10th there was a steady improvement in all the symptoms. Liq. arsenic. was added to treatment, which was left on August 5, recommending patient to still continue the arsenic mixture. Weight, September 30, 9 st. 3 lbs., against 8 st. 12 lbs. in July.

Case 19.—Mrs. J., aged 26. Had had three children, last born four months ago. Her father died from pulmonary affection at 56. She had suffered with her lungs since she could remember. About the end of June last had cold shivers, followed by fever, and had to take to her bed. Was attended by her physician to the 15th July, when I was called. Profuse mattery, offensive-smelling expectoration, profuse night sweats and great dyspnoea, with temperature a little above 99°, were the chief symptoms. Atropine pills, 2% carbolic acid spray and creasote cum glyceri. et alcohol enabled her to call on me on the 28th July. On examination: Sinking in of right side of the chest. Large cavity occupying apex and middle of right lung, while basis of same is almost impervious to air. Small cavity near angle of scapula on left side. Pneumatic treatment of compressed air only, at moderate pressure was commenced to relieve asthmatic and dyspnoeic troubles, and to check expectoration. Spray of hydrarg. perchlori 1-1000 was substituted for that of carbolic acid, but was not tolerated. Expectoration lost its offensiveness after 10th or 12th sitting, and was reduced from more than a cup in the twenty-four hours to a little over a quarter of a cup by 20 August. Appetite improved and dyspnoea relieved.

Case 6.—Mr. B., age 36, cook, married; called February 7. No hereditary history. Had always been well. Having exposed himself to a draught of cold air while over-heated, was seized by cold shivers, followed by swelling of the cervical and bronchial lymphatic glands, and few days later by cough, difficult breathing, etc. In two weeks he had lost nearly a stone in weight. It was a clear case of primitive inflammation of tracheo-bronchial glands a frigore. Under generous doses of potas. iodi. et tr. cincho., and a few sittings of compressed air, he was well again by March 30. All bronchial symptoms having disappeared, and having gained in weight considerably, he left off treatment; but on May the 2nd, having exposed himself again, had a fresh attack. Prescribed the iodide again, but never saw patient after. Heard that he was pursuing his business and felt quite well.

Case 18.—Mr. W., 33, married, fireman; called July 7. P., 75; resp., 20; temp., normal. No hereditary history. In August, 1886, caught a cold, as a consequence of which had gradually

been losing in weight, getting weak, his voice hoarse, very troublesome cough, disturbed sleep, etc., etc.; which symptoms were all present at time of call. Examination: Depression of left sub-clavicular spaces, with feeble, jerking expiration at left apex. Fine and medium rales on right side posteriorly all round contour of scapula. No appreciable alteration of vocal or percussion resonance. There was one noticeable circumstance, viz., that whenever he slept on board, about four 4 o'clock in the morning he would be seized by an asthmatic attack. Chronic bronchitis, aggravated, no doubt, by the inhalations of dust, etc., connected with his occupation. To relieve dyspnoea and irritative cough arising from catarrhal hyperæmic and swollen tissues, compressed air was used for its simple mechanical antilogistic action. Ammon. chlori. and vin. ipec. spray was used to promote expectoration, with cod oil and pil. arsen., his weight having fallen from 9st. 13 lbs. to 9st. 8½ lbs. He improved rapidly and was able to return to his work after two weeks, but had to leave it again on the 18th August, the old symptoms having returned after few days' work, and the asthmatic attacks coming on regularly between the hours of 1 and 4 a.m., whether sleeping on board or not. Previous treatment resumed on same day, with the addition of some anti-asthmatic to be used at time of attack. He improved steadily, and found greatest relief for the asthmatic attacks from the succ. conii spray. Weight, on September 30, 9st. 12 lbs. Attacks occurring occasionally about six in the morning, and disappearing after expectoration.

Case 12.—Mrs. F., teacher of singing. I regret to have mislaid the notes taken of this case, which was one of pleuritis adhesiva chronica, which had led to superficial respiration on account of the pain and incomplete exchange of gases, with all its effects on nutrition generally. Long sittings of compressed air were used, later on followed by rarefied air in the lateral position on the healthy side. Had about 20 or 22 sittings from April 5 to May 11, when she left feeling quite well. Never heard of her since.

Case 20.—Mr. L., 28, married, cook. Consulted me about a year ago for hypertrophy of the mucous membrane of the nose, the consequence of chronic catarrh, from which he had suffered for nearly two years previously. In August last consulted me again while suffering from acute bronchitis, with loss of voice, &c. He had had many such attacks during the last three years, and each succeeding one left him weaker, while it reduced his weight considerably in a week or ten days, this time having lost 8 lb. It generally took from six to eight weeks to recover from each attack. I treated him on ordinary general

treatment for ten or twelve days, but with no improvement. He was ordered on August 20 compressed air, and later on a few cylinders of rarefied air with it. The improvement commenced on the third day, all catarrhal symptoms disappearing, and continued steadily. Cod-liver oil was added about 28th August. Had gained nearly 3 lbs. by 24th September.

I have notes of several other cases which I will publish at some future time. In conclusion I may state that in the pneumatic treatment we have the most reliable agent to relieve these symptoms—cough, expectoration, asthma, and dyspnoea from bronchial troubles.

2.—That it is of undoubted benefit in all conditions of primary infiltration, and that peri and inter-vesicular exudation is capable of cure by this method.

3.—That no other therapeutic agent can restore to a healthy condition lungs just recovering from acute disease as this method can.

4.—That even third stage phthisis is greatly benefited by it.

261 Elizabeth-street, Hyde Park, Sydney.

THE MEDICAL SOCIETY OF VICTORIA AND DR. SPRINGTHORPE.

SHORTLY before the last election of honorary medical officers to the Melbourne Hospital, the Council of the Medical Society of Victoria, as will be remembered, forwarded to the Council of the Royal College of Physicians in London a circular issued by Dr. Springthorpe, of Melbourne, a member of the College, who was one of the candidates for election. The following is a copy of the reply received from the Registrar of the College:—

Royal College of Physicians,
London, S.W., 24th August, 1887.

Sir,—I beg leave to acknowledge the receipt of your communication of 5th July, enclosing copy of a circular issued by J. W. Springthorpe, M.A., M.D. (M.R.C.P. London), to the governors and subscribers, Melbourne Hospital.

As your communication does not state that the issue of that circular is an infringement of any local law or regulation, and as it does not differ from circulars issued by fellows and members of this College under like circumstances, I shall feel obliged by your stating, for the information of the Council of this College, why the Medical Society of Victoria has addressed the Council on this matter.—I remain, Sir, Yours faithfully,

HENRY A. PITMAN, Registrar.

H. B. Allan, Esq., M.D., Honorary Secretary Medical Society of Victoria.

ORIGINAL TRANSLATION.

ON THE ETIOLOGY OF MALARIA.

BY PROFESSOR FERDINAND COHN, OF BRESLAU ;
TRANSLATED FROM UHLWORM AND BEHRENS
BOTANISCHES CENTRAL BLATT XXXI,
288-290 (1887), AND COMMUNICATED BY
BARON SIR FERD. VON MUELLER,
K.C.M.G., PH. AND M.D., F.R.S., F.C.S.,
&C., GOVT. BOTANIST, MELBOURNE.

Our knowledge of the true cause of malaria was hitherto complicated through the preconceived idea that it could solely originate in stagnant water, and that the germs of malaria-fever were only to be found in micro-organisms of swamp-water. But many of the visitors to Italy will have observed that, while the swampy districts are certainly much subject to malaria, especially lagoons near the sea containing brackish water, yet just as often or perhaps even more frequently malaria does exist there as well as in hilly country, in even quite dry localities, in forests and particularly in culture regions. The towns of ancient Latium and Etruria, in which—so far as they are at all still inhabitable—70 per cent. of the deaths are owing to malaria, are all built on hills or mountain-sides. Hadrian's Villa, a notorious place for malaria, is situated high up in the Sabine mountains. In Rome itself, the low lying quarters, which are even occasionally subject to inundation by the Tiber, are closely inhabited and relatively salubrious, while the Palatine and Lateran hills, the Villa Doria Pamphili, the Villa Mellini or Monte Maria are not inhabitable till late in autumn on account of malaria. Even the promenades of Monte Pincio become insalubrious after sunset and are, therefore, then deserted, whereas the low lying Corso and the Piazza Colonna are crowded till late at night. All these phenomena find their explanation in the researches instituted by Klebs and Tommasi-Crudeli regarding the bearer of malaria poison—the bacillus malaria. During the year 1879 these investigators discovered in the air of the Roman Campagna a spore-forming bacillus in the shape of slender, sometimes short, sometimes longer and finer bacillar bodies, which were also found—though as a rule less frequently—in the waters of malaria infested districts. By inoculation of this bacillus, fever was always generated in animals. In a publication on the climate of Rome, issued last year, Tommasi-Crudeli points out that bacillus malariae is a wide spread

bacterial organism, appearing principally in earthy soil, which after moderate saturation with humidity has got dry, but occurs much more rarely in water. Its propagation and formation of spores is greatly stimulated by contact with the air, by a high temperature and by slight submersion. Soil which has become moistened by dew, or by light rain, and in which the malaria-bacillus has established itself, becomes partly changed into dust on getting dry, by which means the germs are carried in vast quantities through the air and thus, also, into the human body, infecting the latter with malarian fever. Of late years the results of Klebs and Tommasi-Crudeli have frequently been doubted, and other supposed micro-organisms, like the so-called plasmodium-malariae, have been regarded as the causes of malaria-infection; this plasmodium has however proved to be merely a morbid alteration of the blood-corpuscles as a result of the fever, not as its cause. On the occasion of a stay at Pola in April last, Professor Cohn made the acquaintance of a young physician, Dr. Schiavuzzi, who during the preceding year had been closely engaged on researches on malaria in the neighbourhood of Pola, and whose investigations had brought decisive results. As elsewhere, there are some localities near Pola, which are infected by malaria, while others are free from it. With the aid of Koch's apparatus and some simple contrivances, invented by himself, Dr. Schiavuzzi investigated the air in fever-stricken districts, and always found the bacillus-malariae in greatest quantity where the temperature of the air and of the soil rose highest, and where in correlation to this also the intensity of the malaria increased; whereas contrarily the bacillus was nowhere discovered in the air of places unaffected by malaria. Nor was the malaria-bacillus found in running water at Pola, although it was present in the water of infected localities, though rarely so. Dr. Schiavuzzi propagated the malaria-bacillus, obtained from the air, quite plainly in gelatine; with this he inoculated small white rabbits, generating thereby a fever, which showed the type of malaria as demonstrated by the diagnostic changes of temperature. On dissection, the well-known characteristics of malaria were exhibited, namely swelling of the spleen, formation of black pigment and amoboid degeneration of the red blood-corpuscles. The same kind of bacillus which had caused the infection was found in the spleen, the lymphatic glands and also, but less copiously, in the blood, and could also be reared again therefrom. Professor Cohn, received from Dr. Schiavuzzi all the specimens secured by him, both from the air and from the water near Pola, as well as samples obtained through direct cul-

ture of the bacillus-malariae, and the Italian physician further supplied all his pathologic anatomical preparations. Professor Cohn is, therefore, with Professor Tommasi-Crudeli in a good position to confirm the exactness of Dr. Schiavuzzi's experiments, according to which the etiology of malaria rests in infection from bacillus-malariae generated in regions—though moist, yet not permanently inundated, the fever-bearers being carried through the atmosphere when the air is at a high temperature.

[Some years ago Professor Naegeli, of Munich, arrived at similar results, especially so far as to show that soils, constantly dry or constantly submerged, were precluding the development of any fever-bearing micro-organism. A long while since Dr. Salisbury, in Mauritius, also succeeded in obtaining from the air—particularly in low-lying localities—a fever-causing bacillus by his experiments there. In all probability the prevailing direction of the currents of the atmosphere has in these considerations to be carefully studied, because the atom-like bodies of the malarian bacillus might most readily be carried from alternately wet and drying soils by ærial force to far distant and even dry and elevated localities. The recent researches by Dr. Frankland in connection with these very subjects are also of very great importance.—F.v.M.]

PROCEEDINGS OF SOCIETIES.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE 67th General Meeting of the Branch was held in the Royal Society's Rooms, Sydney, 7th October, 1887, at 8.15 p.m.

Present—The Hon. Dr. Creed, M.L.C., in the chair; Drs. Clubbe, Wm. Chisholm, Quaife, M'Cormick, Twynam, Thring, Hankins, Power, Steel, Maher, Sydney Jones, Garrett, Martin, Marshall, Kendall, Worrall, Foreman, Munro, Pockley, Reddall, Parker, Wood, Huxtable, and Scot Skirving.

Visitors—Drs. Goode and Leacock.

The minutes of the previous meeting were read and confirmed.

The president announced that since the last meeting of the branch two members had died, namely, Drs. Hoff and Markey.

Dr. G. E. TWYNAM proposed, and Dr. QUAIFFE seconded, "That the New South Wales Branch of the British Medical Association desires to place on record its extreme regret at the loss it has sustained in the deaths of Drs. Hoff and Markey as members of the Society, and that a letter of condolence be forwarded to the widow of the latter gentleman." Carried.

The president stated that the Council had passed the following resolutions relating to the Medical Bill:—"That, in the opinion of the New South Wales Branch of the British Medical Association, it is not desirable

that any Medical Bill should be introduced into Parliament during the coming Session by a member of the profession, as it is of opinion, having in view the recent revelations with regard to unqualified practitioners in this colony, that the Government will deem it necessary to introduce a measure for the required reform;" and "That a copy of the foregoing resolution be forwarded to Dr. Cortis."

Dr. POCKLEY moved—"That the action of the Council with regard to the matter relating to the Medical Bill be confirmed." Seconded by Dr. Ramsden Wood, and carried.

The first business on the paper was the adjourned discussion on Dr. Skirving's paper on "Tracheotomy."

Dr. G. E. TWYNAM said that the question of tracheotomy had occupied their attention very considerably, and would no doubt crop up about every five years, as something fresh regarding it was brought to light. The statistics of Drs. Lovett and Munro, of Boston, appear to be the most reliable on the subject. It appears from these statistics that, during the winter months, there are fewer patients who recover than at any other time in the year. This, no doubt, arises from not being able to keep up an even temperature. It is remarkable how the disease extends in children under two years of age. The extension takes place downwards, and the children die from asphyxia. Another point brought out is the nature of the discharge. If the discharge is gummy, and the tubes have to be removed, frequently to be cleaned out, the patient has not nearly the same chance as when the discharge is loose. A statement was made as to the isthmus not being seen during the operation. He (Dr. Twynam) had seen it distinctly on several occasions. As to whether we should introduce the tubes into the trachea immediately the incision is made, it would seem advisable to keep the wound open and let some of the mucus membrane be coughed up, this will save clogging the tubes as soon as they are placed in position, and will save an immense amount of trouble. With regard to anaesthetics, a great deal of consideration should be given to each case, and only sufficient chloroform given to the patient to enable us to make the first incision. In doing the deeper dissection a knife was better, in his opinion, than two pairs of forceps, as suggested by Dr. Skirving.

Dr. SCOT SKIRVING, in reply, said that Dr. Thring's remarks regarding Brown-Sequard's observations on anaesthesia in the neck were new to him, and seemed to have a practical bearing on the use of anaesthetics, a small amount at the beginning of the operation being what was mainly indicated. In reply to Dr. Pockley, he (Dr. Skirving) said that in a large number of cases he had recognised the isthmus. It did not signify if it were cut. As to what Dr. Brady had said, he wished to explain that in young children, once laryngeal symptoms were present, the case usually went from bad to worse. In the larger larynx of adults the case was different. He had seen membrane in the larynx with the laryngoscope, and yet the case recovered without any asphyxial symptoms. He (Dr. Skirving) agreed with Dr. Twynam with regard to the great value of the American paper that gentleman had referred to.

Mr. G. T. HANKINS described in a graphic and interesting manner the measurement of the galvanic current, and exhibited a simple form of galvanometer, suitable for medical use. This latter was examined by the members, and excited a great deal of interest.

The hon. secretary read a paper for Dr. Leacock on "Hydatids in Bone," which will be found on page 29.

Dr. CLUBBE said about three months ago a girl came

to him with a well-defined swelling in the knee. He (Dr. Clubbe) sent her to St. Vincent's, where she was operated on by Dr. Wm. Chisholm, who found that she was suffering from hydatids in the bone. The peculiar feature about the case was that the growth appeared to be solid instead of fluid.

DR. TWYNAM said that we, in this country, must ever be on the look-out for hydatids, and find them in almost every possible place; but it is very rare to find them in the bone. Dr. Leacock was to be congratulated on the result of the operation.

Dr. LEACOCK replied, and said that when operating they were certainly not expecting to find hydatids. He (Dr. Leacock) thanked the members for the interest taken in the case.

Dr. ODILLO MAHER read some notes on a "Rare Form of Tumours on the Eyelids." The patient was exhibited and examined.

Dr. MAHER also exhibited an electrical ophthalmoscope.

SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

MONTHLY Meeting, held at the Adelaide Hospital, October 27, 1887.

Present:—The President (Dr. Davies Thomas), Prof. Watson, Drs. Mackintosh, Poulton, Stewart, Stirling, Symon, Messrs Aitken, Brummitt, Clindening, Jay, Hayward, Lawrence, and the Hon. Sec. (Mr Cleland).

The minutes of the meeting, held September 29, 1887, were read and confirmed.

The Secretary reported that satisfactory arrangements had been made with the publisher of the *Australasian Medical Gazette* for the supplying to each member a copy of the *Gazette* as published monthly.

BALLOT.—Alfred W. Hill, M.R.C.S., Eng., was elected a member of the South Australian Branch of the British Medical Association.

PATHOLOGICAL SPECIMENS.—Prof. WATSON showed a well-marked specimen of atheroma of the aorta, and of the main arteries springing from the arch.

Also, a dissection made by Mr LYNCH, medical student, of the structures and parts around the encephaloid sarcoma described in the subjoined paper.

Also, the liver and heart, of the case of acute yellow atrophy of the liver.

W. GARDNER, M.D., then read the notes of a case of acute yellow atrophy of the liver that occurred in the Adelaide Hospital (see page 35).

Dr. POULTON said he saw this case first on August 6. She then said she had been ailing a few days, and that in June last she had miscarried when pregnant five months. On August 6 the patient was suffering from primary syphilis, developed secondary cutaneous symptoms during the following fortnight, and her primary sore healed. Slight icterus was noted on the 18th, the patient at the time going about and feeling very well. The icterus disappeared in a few days, and the patient ceased to attend. Dr. Poulton thought these observations valuable as indicating the earlier history of the case.

Dr. STIRLING referred to the interest attaching to these cases of acute yellow atrophy of the liver, on account of their showing to some extent the steps or series of products that were formed by nitrogenous compounds before they appeared as urea in the urine.

It was now known that urea was not formed solely in the kidney, if at all, and that the renal function was more that of an excretory one. Where then was urea formed, and what were its antecedents? One of these is probably leucin, which in passing through the liver is converted into urea. This has been demonstrated by injecting leucin into the portal veins, and ascertaining its conversion in passing through the hepatic structure. Tyrosin is probably another antecedent product before the formation of urea, but the actual demonstration has not been so easily made in this case. If then it is the function of the liver to convert these substances into urea, it is easy to see why they should appear in the urine, in abnormal quantity, in acute pathological conditions of the organ.

The President (Dr. DAVIES THOMAS) remarked that leucin and tyrosin were found in the urine in other diseases than that of acute yellow atrophy of the liver, as for instance enteric fever. There was evidently then some additional factor besides mere destruction of hepatic structure, for the occasional appearance of these substances in the urine.

Prof. WATSON then read the notes of a case of encephaloid cancer at the elbow, which had during life simulated an aneurism, together with a detailed description of the arrangement of the structures (see page 36).

Dr. STIRLING said that having seen the last case before operation, he was of opinion that no other diagnosis could have been made than that of aneurism, unless indeed a portion of the tumour had been removed and examined microscopically. The interest of the case was the site of the tumour. It was common enough to have such masked growths in the palm of the hand, where they were confined by the dense aponeurotic tissue. He would recommend to the notice of the members Mr Holmes's article in the St. George Hospital reports on "Pulsating tumours that were not aneurism, and aneurisms that did not pulsate."

MEDICAL SECTION OF THE ROYAL SOCIETY OF NEW SOUTH WALES.

Meeting held in the Society's Rooms, Sydney, on August 19, 1887.

MEMBERS PRESENT:—Dr. Sydney Jones (President), in the chair, Drs. Knaggs, Skirving, Goode, Ross, Faithfull, Chambers, Chisholm, Crago, Power, Milford, Hankins, Lyden, Martin, Worrall, Brady, Twynam, Clune, Fiaschi, Garrett, MacLaurin, Mander Jones, Ellis, West, Anderson Stuart, and MacCormick and Jenkins (hon. secretaries).

Dr. KNAGGS exhibited for Dr. ROTH a new spirometer and dynamometer, and explained the mechanism of both.

Dr. SYDNEY JONES regarded these instruments of little practical value in individual cases, but useful when statistics of large numbers of cases were kept, as tending to show the physique of a nation.

Drs. MILFORD, GARRETT, FAITHFULL, CRAGO, and SKIRVING, remarked that neither instrument was made use of in the insurance societies of which they were the medical officers.

Dr. CHAMBERS then exhibited specimens—

- (1) Hair-pin from urethra of girl aged 13. The hair-pin was inserted by the girl, and voided without surgical interference.

(2) New growth from "Vulva," removed by Paquelin cautery. Of doubtful nature, but probably epithelioma or condyloma.

(3) *Uterine Fibroid*, from a woman aged 42. The whole uterus and appendages were removed, and the patient made a perfect recovery. A small intra-uterine polypus, protruded through cervix. The difficulties in diagnosis were many and great before the operation.

Dr. BRADY gave history of a child with stone in bladder formed round a "pin." The child was only three years old.

Dr. GARRETT exhibited the middle finger of his left hand, and the forefinger of his right, both in a condition of dry gangrene from accidental application of pure carbolic acid.

Dr. GOODE related a similar case from a 1 in 20 solution of carbolic lotion, and Dr. MACCORMICK made some remarks on the anæsthetic and caustic action of carbolic acid, and the necessity of using warm water for diluting it.

The meeting terminated at 9.50.

Meeting held on September 16 (Dr. Sydney Jones in the chair), there were also present:—Drs. Twynam, Chisholm, Goode, Waugh, Mander Jones, Faithfull, MacCulloch, Quaife, MacCormick, Jenkins, Sir Alfred Roberts, Brady, Worrall, Garrett, Skirving, Fiaschi, and Carruthers.

The minutes of previous meeting having been read and confirmed,

Mr. TWYNAM read papers on two cases of amputation at the hip joint, and both patients were exhibited. One excited great interest, as the diseased bone which necessitated the operation was caused by "caisson fever," contracted March 6, 1882, the patient working under a pressure of 45lbs to the square inch.

Sir ALFRED ROBERTS made some remarks, having seen the patient in the interest of the Government some time back, and that then there was exquisite tenderness over the right thigh, muscular pains, lung troubles, and great deviations in the temperature.

Dr. JONES also joined in the discussion, and congratulated Mr. Twynam on the successful issue of his cases.

Dr. MACCULLOCH exhibited a patient with a marked curvature of left tibia. There had been a previous fracture of the fibula, but no fracture of the tibia. The bending commenced some considerable time after the accident. Drs. BRADY, WAUGH, and MACCORMICK joined in the discussion.

Dr. MACCORMICK exhibited a small piece of bone tipped with cartilage, that he had removed from the knee-joint.

Dr. SYDNEY JONES exhibited a peculiar growth he had removed from the anterior bone of axilla "anepithelial growth, with colloid degeneration."

Drs. TWYNAM and SKIRVING joined in the discussion.

The meeting terminated at 10 p.m.

Meeting held on October 21, 1887. Present—Dr. Sydney Jones (in the chair), Drs. Blaxland, MacAllister, Faithfull, Kendall, Ross, Roth, Anderson Stuart, Garrett, Crago, Lyden, Waugh, Theophilus Jones, Chisholm, Goode, Deck, Knaggs, Hankins, Twynam, Worrall, Brady, Power, Wright, Phillips, MacCulloch, Fiaschi, Quaife, MacCormick, and Jenkins.

Dr. CHISHOLM read notes on a case of "gastrostomy," and exhibited the patient, who fed himself through a glass funnel with milk. The true cause of the oesophageal stricture was obscure.

Mr. HANKINS gave history of three cases of "gastrostomy," two in adults, both of whom died, one from symptoms of peritonitis, and the other from inanition; and the third a child. The smallest bougie could not be passed. The first stage of the operation was performed, and then a No. 1 catheter was passed, and it was found unnecessary to perform the second stage.

Drs. MACCORMICK, BRADY, ANDERSON STUART, and SYDNEY JONES, joined in the discussion.

Dr. WAUGH then exhibited a case of "vicious union" of the tibia—the lower half of tibia and fibula set at right angles to upper half. He was treated in the Melbourne Hospital, but left three weeks after admission, and was warned of the dangers.

Dr. GOODE read a paper on a case of "Excision of the Rectum," and showed the case. Drs. TWYNAM and SYDNEY JONES made remarks as to the benefits of the operation, the methods, the prevention of bleeding, &c.

Dr. SYDNEY JONES then read, for Dr. MANDER JONES, a paper on a case of "Intestinal Obstruction" in a woman aged 22, following inflammation after abortion. Dr. Sydney Jones opened the abdomen, and found the obstruction due to a dense band connecting the ileum and colon, with a mesenteric gland involved. The adhesion was cut through, and the patient made an excellent recovery. Drs. ROSS, Crago, MACCORMICK, TWYNAM, and WORRALL, joined in discussion, the latter urging immediate operative interference in cases with urgent symptoms.

Dr. SYDNEY JONES replied.

Dr. GOODE exhibited:—

(1) Strangulated femoral hernia.

(2) An enormous fatty tumour.

The meeting ended at 10.20.

SYDNEY UNIVERSITY MEDICAL SOCIETY.

THE usual monthly meeting of the above Society was held in the Clinical Theatre, Prince Alfred Hospital, Sydney, on the evening of Friday, October 28. The Hon. President, Dr. Graham, was in the chair. There was a very good attendance of members. The minutes of the last meeting was read and adopted. Mr. MacKenzie, of the Edinburgh University Medical School, was elected a member of the Society. On the proposal of Mr. Neill, it was decided that the last meeting of the Society for this year take the form of a social, and a committee was appointed to make arrangements for the same. The general business having been finished, a paper was read by Dr. S. T. Knaggs, he taking for his subject, "Lessons that we may learn from the lives of eminent medical men." In the reading of the paper, he instanced in particular the lives of John Hunter, William Harvey and Jenner, as those that a student would do well to strive and emulate. The paper proved very interesting and much good advice was given, students being especially exhorted to persevere with their studies and be industrious; the lives of the three men adduced, especially in the case of Jenner, showing what can be done by indefatigable industry and perseverance. At the conclusion of the paper, a vote of thanks was proposed by Mr. Purser and seconded by Mr. Neill. Other gentlemen who spoke were Dr. Graham, Messrs. Mills, Trindall, Binnie, and Professor Stuart. Dr. Knaggs having replied, the meeting terminated.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, NOVEMBER 15, 1887.

EDITORIALS.

[Contributed.]

QUARANTINE IN QUEENSLAND.

THE elasticity of quarantine laws and the calm indifference with which they may be broken, is too well known to need any deep or forcible argument for its proof.

At the present time, Queensland affords an interesting study as to whether measles shall, or shall not, necessitate quarantine. The mere fact that the Quarantine Act states that 14 days' quarantine shall be undergone for measles, from the termination of the last case, is quite immaterial in the opinion of certain of the Health Officers up North, and the superb indifference with which, in some instances, vessels having actually measles on board have been granted pratique, excites the envy and admiration of those more conscientious gentlemen who have carried out the law as provided by the last Quarantine Act. It is, however, a matter for regret that the *Brisbane Courier* should have seen fit to insert a sub-leader condemning the action of Dr. Salter, the Health Officer at Thursday Island, for refusing pratique to the s.s. "Bulimba," seeing that a case of measles was at the time existent on board. Dr. Salter simply, in the exercise of his duties, as laid down by the present laws, acted as they direct and placed the vessel in quarantine. Surely the *Brisbane Courier* must acknowledge that it is not the instrument of the law that is to blame, if blame there be, but the law itself, for any unnecessary harshness in the case in point. The "Bulimba" proceeded to Cooktown, where she received pratique two days after being refused at Thursday Island, and no more was said about quarantine for the rest of the voyage. The 450 immigrants she brought out were disembarked at their various ports of destination, and as the

"Bulimba" arrived at Brisbane within 10 days of leaving Thursday Island, there is, at all events, some little chance of various centres of disease springing up should any of the passengers have become infected during their voyage down the coast, for it is generally acknowledged that 12 days at least must elapse before the danger is over of the disease re-appearing. In the "Bulimba" case this period had not elapsed, and it seems decidedly to have created a bad precedent, for the following immigrant vessel, the "Duke of Devonshire," although refused pratique at Thursday Island and Cooktown, there being several cases of measles on board, was granted it at Townsville, the Health Officer there even going out of his way to say that it was absurd to have quarantined the ship for measles. It was, doubtless, a graceful act on the part of the Health Officer at Townsville to pass a vessel on which measles had recently existed, and, at the present time, when medical men are numerous and illnesses scarce, will be a boon to the profession in North Queensland, which, it is to be hoped, his brethren will estimate at its true worth should measles be disseminated in the Townsville district.

Of course no one will deny that it is quite probable that no evil will come of the action of the Health Officer at Townsville, but the bare possibility of an epidemic should have been avoided, and it was for this purpose that the present stringent Quarantine Act was passed. If Health Officers are to ignore its provisions unrebuked, there will, no doubt, be, some day, the pleasing (?) spectacle of medical gentlemen announcing the absurdity of quarantining for small-pox, and allowing vessels with that disease, or perhaps cholera, to be granted pratique. Will the *Brisbane Courier* support such a case is a matter for open question, after the implied ignorance displayed by the writer of the sub-leader referred to, of even the most rudimentary knowledge of the laws of infection and contagion. His ignorance of the fact that measles, when affecting the black races, assumes an almost typhus type, and is extremely fatal, was to be expected, for, knowing the number of natives on Thursday and adjacent islands, he would have refrained from condemning Dr. Salter's action had he not been absolutely destitute of all information on the subject of measles. The whole circumstances of the above cases only tend to prove more clearly what has been so frequently requested by the profession in the Colonies, that is, the establishment of stringent federal quarantine laws and stations. The subject has been so frequently handled, and so conclusively argued out, that little more remains to be said in its favor that has not been already well and ably put before the public. But it is only

by continually bringing to light such instances of contradictory professional opinions and decisions, as evidenced by the Northern Queensland Health Officers, that the absolute necessity for the framing of Federal Quarantine Regulations will be brought home to the minds of our legislators.

Quarantine in any form must, of necessity, be unpopular, and the outcry of the general public that it is a pet, and unnecessary bug-bear, forced upon them by our own profession for our own benefit, is only the outcome of the various muddles and *contretemps* which, in many instances, have occurred in carrying it out. Surely, therefore, it is time for the various medical associations to urge upon the different Colonial Governments the utility and necessity for uniform laws for the prevention of the introduction of disease into the Colonies. If necessary, there might be a conference of those gentlemen whose special knowledge of sanitary laws affecting each Colony, might lead to the framing of some definite federal law on the subject of quarantine. This conference might, if advisable, be held at the expense of the various Colonies, and might be given the power to draw up a comprehensive scheme of federal quarantine. In any case, the subject is an important one, and one that should not be allowed to drop.

LETTERS TO THE EDITOR.

TYPHOID FEVER VERSUS MILK.

(To the Editor *Australasian Medical Gazette*.)

SIR,—The "Melbourne Letter" of October 22, which appeared in the *Sydney Morning Herald* of 26, has a paragraph devoted to typhoid fever, as referred to in the report of the Central Board of Health. It draws a contrast between towns in older countries, with closely packed slums, filled by a degraded population, where one naturally expects to find disease rife. Still, it goes on to say that such towns show a decreasing mortality, whereas in our larger new towns, where opportunities are effected for improved sanitation, the mortality from typhoid fever is steadily rising to an alarming extent, out of all proportion to the increase of population.

Instancing Frankfort-on-the-Maine, as typical of one unhealthy medieval town, where the mortality has fallen by improved sanitation to 2·3, it has risen in Australia, with all its advantages, to 7·3 per 10,000.

The mortality from railway accidents, or disasters by sea, is small compared to this, and even the deaths from the dreaded small-pox are fewer.

Typhoid fever is a preventable disease when a proper system of sanitation is carried out. The defective drainage of Melbourne, and the impure water supply, are leading factors in the spread of typhoid there. It is well known that in the majority of the streets in Melbourne and the suburbs, the slops and sewage flow in the gutter, and to pass along some of the chief low-lying streets late at night, when the soakage in the cellars is being pumped out, is quite as bad as sailing down the Yarra on a warm day, when the propeller of

your steamer has churned up the sewage of which the said river is the receptacle. I have experienced both sensations, and in my travels in the east have never encountered anything so offensive.

A dead elephant in the Indian jungle never becomes so high as to approach it. The vultures, acting the part of scavengers there, pounce on their prey almost before the breath has left the body, and the smell quickly disappears. In Melbourne, however, the danger is always present. New South Wales has not much to boast of in respect of advanced sanitation. If Sydney is ahead of Melbourne in respect of systematic drainage and a purer water supply, typhoid germs may be brought in from the surrounding districts in a way unthought of by the sanitary authorities. It is well known that the Illawarra district sends a large quantity of dairy produce to Sydney. Is any supervision exercised over the numerous butter-factories and dairy-farms in the Illawarra district? In Kiama, the centre of this district, and the port whence most of this produce is shipped to Sydney, an epidemic of typhoid fever existed a few months ago, attended with considerable mortality. During this epidemic, milk was actually carried from a house, where fever had a few days before been raging, to a patient in the Hospital, and was supplied also to regular customers. Pigs are kept in large numbers at some of the factories, and in passing one recently the stench could be distinctly smelt several hundred yards along the main road. It would be well if the proprietors of factories in the district could assure the community through their Secretaries or Managers, that proper means were periodically adopted to keep the piggeries attached to the factories where the butter is made for the Sydney market in a clean and wholesome condition. If the smell of a factory piggery can be distinguished hundreds of yards distant from the place where the milk is taken to have the butter extracted from it, what must be the danger to the aerated milk, cream, and butter in the adjacent factory carrying away poison germs, and so propagating fever and other diseases?

The Aylesbury Dairy Co.'s arrangements, if adopted in the Illawarra District and carried out with intelligence, would give the Sydney consumers of dairy produce a guarantee of the purity of the articles coming from this quarter which is at present wanting.

Several butter factories are being erected in the Kiama district, and it would be well if the proprietors would place them and the dairy farms supplying the milk for manipulation under medical supervision in so far as the carrying out of systematic sanitation is concerned. An assurance that no pigs were kept near such factories would quickly place them in a favourable light in the eyes of the purchasers of dairy produce.

The Government inquiry instituted at Kiama after fever had abated came to little, the subject having previously been fully written up in a local paper, the *Reporter*. Butter factory proprietors should not permit pigs to be kept in the neighbourhood of the place where butter is made, but instead of this being the case there is at the present time an advertisement for three hundred pigs to be kept at a factory in the Illawarra district.

The filth from the proximity of so many foul animals must have an injurious effect on dairy produce, and to hear of typhoid fever following such produce to Sydney or elsewhere, would not surprise a Sanitarian or

Yours faithfully,

JOHN S. WILSON,
M.R.C.S. Eng., &c., &c.

"Brighton Villa,"
Kiama, Nov. 3, 1887.

CASES SHOWING UNUSUAL SYMPTOMS.

(To the Editor of the A.M.G.)

SIR,—A point in each of the two following cases may be interesting to some of the readers of the A. M. Gazette:—

1. On my second visit to a case of ulcer of the stomach, the patient's urine was shown to me, which I found quite bloody. For a moment this symptom puzzled me, but I felt relieved when I thought it might be the effect of oil of turpentine that I had been using in stripes applied to the epigastrium. This it proved to be, for after a short time the hæmaturia disappeared when the turpentine was discontinued. I had had it used by mixing two ounces with a sufficient quantity of hot water, and applying flannels wrung out of this. Such rapid absorption by the skin, and action on the kidneys of turpentine is, I think, unusual, and, as it is so, when hæmaturia appears in this way again, it may cause unnecessary alarm both to patient and physician.

2. I was called eighteen miles to see a child who had shewn alarming symptoms. On my arrival, I found a well-nourished boy, a year old, lying on his mother's lap, and looking somewhat exhausted. I was told that he had had a natural motion at midnight; that at 2.30 he awoke as if in great pain, when the mother gave a dose of castor oil, which was apparently retained; that from that time till 8 a.m., there had been frequent paroxysms of pain, with retching and vomiting; that as the oil had not operated, some more was given at 6 a.m., which was at once returned, and that at 8 a.m. he had passed a small enema of warm water which was deeply coloured with blood immediately after it had been administered. He had been easier on the whole since this, and had been sick only once, at 11 o'clock. The appearance of blood caused the alarm, and made the parents send for assistance. I saw the little patient at 11.30 a.m. As there had been no evacuation of the rectum for 3½ hours, and the child seemed quiet and resting, with only an occasional paroxysm of pain, I determined on waiting and watching before using any active measures, at the same time giving tr. opil and tr. belladonnæ in one minim doses of each, with Schacht's liq. bismuthi every three hours, with small quantities of brandy occasionally, while needed, and keeping up gentle counter-irritation to the abdomen over the stomach and bowels. The restlessness and the retching continued, but to a very slight extent, for three days, during which the temperature (in the axilla) was 99.5° F. On the morning of the 4th day, the child began to regain his spirits, and passed a well-coloured paste-like motion, with only a trace of blood. This was the first time for eighty-two hours, with the exception of the enema and blood, that anything had passed per anum. A little blood was noticed only once again, and then the bismuth began to blacken the stools. Undoubtedly this was a case of intussusception, and considering that the symptoms were so well-marked, it was exceptional for nature to have effected reduction of the incarcerated intestine. I simply aided her in preventing re-displacement. If, however, the parents had (as so many would have done) persisted in administering cathartics, the chances against recovery would have been very great.

Both the above-mentioned cases are now doing well, much to their friends' delight and mine, for the first is the mother of a large family of little ones, and the second, the family favorite.

A. G. E. NAYLOR,
L.R.C.P., et L.R.C.S. EDIN.

Swansea, Tasmania,
7th October, 1887.

A CORRECTION.

(To the Editor of the A. M. Gazette.)

SIR,—In the case of "Hæmophilia" by me in your issue of the 15th inst., referring to the bleeding ceasing and then recurring after an interval, I intended saying, "if this be the case and an *usual*," &c., whereas it appears "and an *unusual*," which alters my meaning altogether.

Please call attention to this error.

Yours truly,

JAMES W. HOPE, F.R.C.P.E.

Freemantle, Western Australia,
October 29, 1887.

THE KIAMA COTTAGE HOSPITAL.

(To the Editor Australasian Medical Gazette.)

DEAR SIR,—Your Editorial notice of the Kiama Cottage Hospital in the *Medical Gazette* of last month must have been based on ex parte information, as neither Chairman, Secretary, Medical Officer, nor Committeeman furnished it, and as it conveys an erroneous impression, I shall thank you for the favour of space for the facts. It is true that four doctors, two of them residing fifteen miles from the Hospital, asked for the privilege of sending their private paying patients to be exclusively treated by them, but in the face of the following rule the Committee could not do this.

20. The Medical Officer shall be elected at the Annual Meeting, or at a special General Meeting if necessary. None but duly qualified medical practitioners shall be eligible for election. The surgical and medical practice of the Institution shall devolve upon him. He shall visit the patients regularly, prescribe all medicines required, regulate the division and classification of patients, have power with the concurrence of a member of the Committee to suspend Nurses or other indoor Servants neglecting to carry out the orders given, and temporarily to appoint others.

Again another rule says:—

25. Patients shall be admitted on the recommendation of qualified members, subject to the approval of the Medical Attendants for the time being, or in case of their absence by the Superintendent, until the first meeting of Committee. Accidents or urgent cases to be received at all hours of the day or night without a recommendation.

But none of the doctors were qualified members. The next two rules are explicit as to where the power to alter rules is vested, and the mode of operation.

6. The Annual or any Special Meeting of subscribers shall have full power to make such additions, alterations, or amendments to the rules of this Institution as may be recommended by the Committee, or by any annual subscriber, provided that notice of such additions, alterations, or amendments be given by advertisement in the local press, and exhibited for inspection in the Hospital 14 days before such meeting.

13. The Secretary shall, on the authority of a resolution of the Committee, or on the requisition of ten subscribers, call a Special General Meeting of the subscribers, of which seven days' notice shall be given by advertisement specifying the business submitted.

The last rule I shall quote is one giving the privilege sought to the Medical Officer only—

33. The Committee may at any time, when there is room, allow the Medical Officer to receive his private patients into the Hospital for treatment, provided that such patient or patients shall pay such daily or weekly sums for their maintenance to the funds of the Institu-

tion as the Committee thereof for the time being may appoint, such maintenance fees in all cases to be guaranteed by the Medical Officer; any patient so received, to be subject to the rules and regulations of the Institution.

But it ought to be known that when this rule was made there were only two medical men in the town, one was favourable to the Hospital movement, and assisted all he could, the other refused to assist, and the former was elected unopposed. Your notice assumes that the Committee came to a decision in the matter adverse to the application, for you say, "We think the decision a mistake in the interests of the the Hospital, and trust to hear shortly that the decision has been reversed." But the fact is, the Committee came to no decision; they simply found themselves powerless in the matter, and said so. Your insertion of the above will oblige,

Yours respectfully,

JOSEPH WESTON.

Kiama, November 5, 1886.

[Nothing in our correspondent's letter affords us any valid reason for changing our opinion as formerly expressed. It is to be hoped that in the interests of the Hospital and the patients (who will assuredly suffer sooner or later under the present bye-laws), the rules which give unusual privileges with regard to private patients to one medical man above another will be changed. The fact that a medical man is not a subscriber affords no valid reason for excluding him from the privilege, this being a matter of taste or sense of duty to his neighbours, which it is not the province of the managing body of the Hospital to enter into.—Ed. *A.M.G.*]

OBITUARY.

RICHARD HARRIS.

WE deeply regret to have to announce the death of Richard Harris, M.R.C.S., Eng. 1830, who died at Newcastle (N.S.W.), on November 3rd. The deceased gentleman came to this colony 48 years ago, and had been practising at Newcastle for a long time past; he held the positions of Government Medical Officer, Port Health Officer, Public Vaccinator, and Visiting Medical Officer of the Newcastle Hospital for the Insane, he also was a Surgeon in the Permanent Artillery. The deceased was 81 years of age, and was highly respected by all classes.

ROBERT PURDIE.

WE regret to have to announce the death of Robert Purdie, M.D., Edin. 1834, L.R.S.A. Lon. 1841, M.R.C.P. Lond. 1862, who died at Grafton (N.S.W.), on October 20, at the ripe age of 78 years. The deceased gentleman arrived in the colony in 1862, and for many years held the position of Government Medical Officer for the Grafton district.

REVIEW.

SPRAINS; THEIR CONSEQUENCES AND TREATMENT.

By C. W. MANSELL MOULLIN, M.A., M.D., OXON.; F.R.C.S. ENG.; ASSISTANT-SURGEON, LONDON HOSPITAL, &c. LONDON, H. K. LEWIS, 1887.

WE have long wished for a work of this kind and cordially welcome this contribution as one likely to be much appreciated. Though it contains nothing startling or novel it has the merit of placing before one, in an easily readable form, most of the injuries likely to be met with in the sprains of joints, muscles and tendons. Hitherto one has had to wade through volumes in order to find out much of what is at once found in this little work. The value of such a book cannot be estimated too highly. There is scarcely any lesion which receives so little consideration, though too often attended by the most untoward results, as sprain. A mass of cripples date the origin of their troubles to some apparently trivial injury to a joint. The by far most important question of treatment in regard to these injuries is treated at some length. Forceful manipulation in the case of stiff joints is favourably noticed. "When carried out properly and scientifically" (whatever this adverbial qualification may imply) the author claims this form of treatment to be "not only more efficacious, but more free from risk than the slow and tedious process of stretching the opposing tissues little by little." It is the great difficulty of accurately determining the cases suitable for forceful manipulation that makes us chary in endorsing the author's warm advocacy. Very serious results have sometimes followed rapid and rough modes of treatment.

A very clear account is given of what is meant by massage, and of the cases to which it is applicable. Massage is not at all synonymous with rubbing. Muscles or groups of muscles are to be operated on in a definite and systematic way. Massage in its proper employment would seem to be peculiarly efficacious with sprains of muscles and with the older sprains of joints.

Sprains of tendons come in for consideration, also those of the back and neck. There is an instructive chapter on internal derangement of the knee, with an account of a good mechanical arrangement for cases of the kind.

The author evidently has had a good experience and seems to have tested thoroughly the efficacy of the treatment preferred. The book is neatly got up and well printed.

THE MONTH.

NEW SOUTH WALES.

THE following telegram was sent on October 18, by the Colonial Secretary of New South Wales, to Mr. Duncan Gillies, Chief Secretary of Victoria, and to the Colonial Secretary of New Zealand, with reference to the quarantine of vessels from Tasmania:—"The Board of Health, while acknowledging that the plan adopted in this instance by Victoria and South Australia gives greater protection against the introduction of smallpox than that in force in New South Wales, yet is of the opinion that the interference with trade and the inconvenience to the travelling public produced thereby are so great as to outweigh the advantage of the additional protection gained. The board therefore thinks it right to treat the colony of Tasmania with the same consideration that was shown to New South Wales and Victoria during former outbreaks of smallpox in those colonies. On all these occasions vessels from the infected colony were admitted to free pratique in the ports of the other colonies after careful medical inspection at the port of arrival. Unless therefore, the outbreak assumes a more serious character, the board feels bound to adhere to its last resolution, by which vessels from Tasmania are to be admitted to the ports of this colony after medical inspection at the port of departure and the port of arrival."—(Signed) HENRY PARKES.

THE "Dairies Supervision Act" has been extended to the Municipal District of Penrith.

THE first lecture on "Invalid Cookery" at the Prince Alfred Hospital, Sydney, was delivered on October 24.

THE foundation stone of the Manning River District Hospital, Taree, was laid by Mr. See on November 2, about 2,000 persons being present from all parts of the district.

THE foundation stone of a new hospital at Silverton, was laid on October 13.

A WOMAN named Julia Constance Campbell, 33 years of age, residing at Marrickville, died while under the influence of chloroform at Dr. Ramsden Woods' private hospital, Stanmore, Sydney, on October 22.

DR. J. F. CODRINGTON, late of Orange, has started practice at Goulburn.

DR. F. H. FURNIVAL, formerly of Mornington, (Vic.) has commenced practice at Auburn, a suburb 11½ miles from Sydney.

DR. H. J. F. GROVES, late of Hillston, and formerly of Taree, has settled at Broken Hill, the centre of the famous silver-mining district, near the South Australian border.

WE regret to learn that Dr. W. McMurray, of Walgett, on October 18, was thrown from his horse and broke his collar-bone.

DR. JAMES MCNISH, of Burwood, has removed to Bulladelah, on the Myall River, 148 miles N. of Sydney.

DR. F. N. MANNING, Inspector-General of the Insane in New South Wales, has returned to the colony from his trip to Europe.

DR. WILLIAM MORRIS, late of Castlereagh-street, after an absence of twelve months, has returned to the colony from his trip to Europe.

DR. W. C. WILKINSON has resigned the position of pathologist at the Prince Alfred Hospital, Sydney.

NEW ZEALAND.

A COMPANY, with a capital of £15,000, has been formed in Christchurch, for the purpose of erecting a first-class hotel, to accommodate forty visitors, at the Hammer Plains Hot Springs, situated 92 miles north of Christchurch, and famed for their efficacy in rheumatism, sciatica, gout, cutaneous diseases, nervous affections, and insomnia.

IN THE Supreme Court, Dunedin, on the 28th September, Justice Williams delivered judgment in the case of Sutherland v. Neill. Sutherland had brought an action for libel against Dr. Neill, because the doctor, as Superintendent of the Seaclyff Lunatic Asylum, had caused to be inserted in a letter forwarded to other superintendents the statement of the reason for Sutherland's dismissal. Sutherland received damages, but the defendant moved to have the plaintiff non-suited. His Honor now non-suited Sutherland with costs.

AT the Supreme Court, Dunedin, on October 10, Michael Kennedy, a station hand, sought to recover £500 damages from Mrs. J. P. Jones, who has a local reputation for curing disease. For the plaintiff it was contended that Mrs. Jones undertook to cure him positively, but after four months under her care he had to go to the Hospital and have part of the floor of his mouth and part of the lower jaw removed. The disease he was suffering from was cancer. For the defence it was denied that the defendant undertook to cure, and only gave harmless herbal ointment at the plaintiff's earnest solicitation. After hearing evidence the jury gave a verdict for defendant with costs.

DR. W. E. HAGON, late Medical Superintendent of Sunnyside Lunatic Asylum, but now practising at Christchurch, was, on September 30, presented with a beautifully illuminated address by the attendants and servants of that institution.

DR. A. G. H. BUCKBY has resigned his position of Honorary Surgeon of the Wairoa Light Horse Volunteers.

DR. CLIFTON CHARLTON, a new arrival, has settled at Tenui, 102 miles N.E. of Wellington.

DR. A. T. PERKINS has commenced practice at Waverley, 30 miles N. of Wanganui.

QUEENSLAND.

DR. J. E. USHER, for many years in the Immigration Service of the Queensland Government, has received a letter from the Under Colonial Secretary cordially recognising the zeal and efficiency which he had displayed in the discharge of his duties during the four years he officiated as Surgeon-Superintendent of immigrant vessels. Dr. Usher during that term made six voyages to the colony and brought out about 3,000 souls. Dr. Usher has gone to Melbourne, where he intends to practise his profession.

DR. A. E. BYRN, late of Hughendon, has removed to Normanton, about 50 miles from the Gulf of Carpentaria.

DR. C. L. CUNNINGHAM, late Surgeon-Superintendent in the Queensland Immigration Service, has commenced practice at Sandgate, a favourite watering-place 13 miles N. of Brisbane.

DR. HARDIE, has commenced practice at 4 Maxwell Place, Ann-street, Brisbane.

DR. ST. GEORGE QUEELY, late of Cairns, has removed to Maytown, the centre of the Palmer River Gold-fields, where he has been appointed Surgeon of the District Hospital.

DR. W. VEREKEE BINDON, formerly House Physician and House Surgeon at the Edinburgh Royal Infirmary, has commenced practice at Wharf-street, Brisbane, in conjunction with Dr. L. Kesteven.

SOUTH AUSTRALIA.

OUR readers will be pleased to hear that Dr. J. C. Verco, of Adelaide, is now convalescing from his illness; he has gone through an attack of typhoid fever, accompanied by tuberculosis of the brain. Dr. Verco was suffering before and during the late Intercolonial Medical Congress, but did not lie up for two weeks after.

DR. H. H. BOVILL, who has been practising at Mount Barker, has been appointed to act as *locum tenens* for Dr. P. M. Wood, the medical officer at Palmerston, Port Darwin, who has received six months' leave of absence.

DR. W. H. BARKER, of Mintaro, has resigned the position of Public Vaccinator.

DR. A. W. HILL, a new arrival, has commenced practice at Melbourne-street, North Adelaide.

DR. JOHN MCNAUGHTON, late of Hamilton (Vic.), has removed to Adelaide, where he has been appointed Junior House Surgeon of the Adelaide Hospital.

DR. P. M. WOOD, Government Health Officer, at Palmerston, Port Darwin, was presented with a purse of sovereigns on November 8, on his leaving for Adelaide on six months' leave.

DR. PENTLAND has been appointed Honorary Officer of Health, for Jamestown.

TASMANIA.

AT the Launceston Police Court, on November 8, Dr. R. W. Murphy, Health Officer, was charged on the information of the secretary of the Board of Health, with having failed to report that Annie Blanche Flowers was suffering from an infectious disease. This was the first case of small-pox. The defendant pleaded guilty, but held the opinion that the case was aggravated chicken-pox. He was fined £25, and costs.

VICTORIA.

A DEPUTATION of representatives of the municipal bodies from all parts of Victoria, waited, on October 19, on Mr. Deakin, asking for the withdrawal of the Health Act Amendment Bill, which provides for an extension of the powers of the Central Board. Several members of Parliament were present. General complaints were submitted regarding the arbitrary and high-handed proceedings of the Central Board which aimed at depriving the Local Boards of Health of all power. A very strong feeling of antagonism was displayed. The Chief Secretary expressed his regret at the evident friction between the Central and Local Boards and promised to revise the bill to meet the views of the deputation as much as possible.

THE Victorian Government intend to erect a new lunatic asylum on the cottage system, near Frankston, on the eastern shores of Port Phillip Bay, 27 miles S.E. of Melbourne.

A MEETING of gentlemen interested in pastoral pursuits was held at Goldsbrough's wool stores, Melbourne, on October 31, to hear Professor Watson, of the Adelaide University, explain his method for the extermination of rabbits by inoculating them with what is known as rabbit scab. It was alleged that the

disease in question was very deadly to rabbits, and that no other animals could be infected with it. The meeting was of opinion that experiments should be made with a view of testing the efficacy of the method in question under natural conditions, and that a piece of land should be enclosed for the purpose. Ultimately it was resolved that funds should be subscribed by those who were interested in the success of the experiments, and that the Government should duly be asked for permission to introduce the scab under the most stringent precautions. On November 2, a deputation waited upon the Premier with this object and to obtain an understanding that the promoters of the scheme shall not be held liable for any injury that may ensue from bringing a new disease to the colony.

PLEURO-PNEUMONIA has made its appearance in some of the dairy herds of the Ballarat district, and has proved very fatal. One farmer has lost over 20 head of cattle, and another 14 head. It appears that the complaint obtained strong hold in the herds before its character was recognised. On one farm seven cows have been destroyed to prevent the infection spreading, and on another the Government Inspector of Stock ordered the destruction of a cow affected with the disease.

A COMPANY with a capital of £20,000 has been formed for the purpose of building a first-class hotel and sanatorium at Hepburn, near Daylesford, noted for the best mineral spring in Victoria, which, in its composition resembles the waters of Cheltenham, Spa, and Schwalbach.

DRS. ALLEN, JACKSON, JAMIESON, NEILD, AND WILLIAMS, of Melbourne, have been appointed, by the Medical Society of Victoria, members of the provisional committee of the next session of the Intercolonial Medical Congress.

A COMPLIMENTARY fancy dress ball was tendered to Dr. Beattie Smith at the Yarra Bend Asylum, on November 9, by the attendants and their friends at the asylum, on the occasion of his return to fill the position of Resident Medical Officer at that institution after an absence of twelve months, during which time he has been in charge of several lunatic asylums in the country districts.

DR. H. E. ASTLES, late of Adelaide, has commenced practice at Collins-street East, Melbourne.

DR. EUGENE ANDERSON, Resident Medical Officer to the Women's Hospital, Carlton, commenced a series of ten lectures on midwifery, to be delivered weekly to the nurses and pupil nurses, on October 28, in the board-room of the hospital.

DR. W. H. CAMPBELL, of East Melbourne has been appointed an Official Visitor to the Sunbury Lunatic Asylum.

DR. FIGG, Health Officer at Williamstown, has, by the authority of the Chief Secretary, been allowed to resume duty.

DR. GEORGE GRAHAM, J.P., of Richmond, has been appointed an Official Visitor, Hospitals for the Insane, Melbourne district, and also at Sunbury.

DR. ANDREW GRANT, has settled at Minyip, in an agricultural district, 227 miles N.W. of Melbourne.

DR. A. HAYNES, of Benalla, has removed to Myrtleford, in a mining and agricultural district, 177 miles N.E. of Melbourne.

DR. T. HODGSON, a graduate of the Melbourne University, has settled at Sunbury, 24 miles N.W. of Melbourne.

DR. TUDOR HORA, late of Dromana and Carlton, and formerly of Western Australia, has succeeded to the

practice of Dr. J. A. Hayden, at Dimboola, on the Wimmera River, 252 miles N.W. of Melbourne.

DR. GEORGE LE FEVRE, of Collins-street east, Melbourne, has been elected a member of the Legislative Council of Victoria.

Dr. G. M. REID, of Castlemaine, has removed to Birregurra, 84 miles S.W. of Melbourne.

DR. SHIRLEY ROBERTS, has settled at Avoca, 126 miles N.W. of Melbourne.

DR. J. G. WYNNE, a recent arrival, has settled at Colac, 96 miles S.W. of Melbourne.

WESTERN AUSTRALIA.

Drs. B. T. HEUSTON AND R. J. LEPPER have exchanged their practices and Government appointments. Dr. Heuston has removed from Busselton to Pinjarrah, and Dr. Lepper from Pinjarrah to Busselton.

MEDICAL NOTES IN PARLIAMENT.

IN THE Legislative Assembly, N. S. Wales, on October 25, Dr. W. R. Cortis, moved:—"That this House will, on Tuesday next (November 1), resolve itself into a Committee of the Whole to consider the expediency of bringing in a bill to enable the public to distinguish registered medical practitioners." He thought hon. members would agree with him that legislation on that subject was most urgently required. What he intended to do, if allowed to bring in that bill, was simply to make it one to enable the public to distinguish registered from unregistered practitioners—not to protect them, but to protect the public from the consequences of their own ignorance and folly. The report of a Select Committee of the Legislative Council showed that there were in this colony 183 persons practising without diplomas, assuming the title of "doctor" or "surgeon," and representing themselves to the public as being educated, and qualified medical practitioners. The bulk of those people had made not only a living, but large fortunes by trading upon the credulity of their fellow-creatures. He contemplated framing the bill in such a way that the title "doctor" or "surgeon" would be regarded simply as a trade mark, against the fraudulent use or misuse of which the public should be protected. The motion was agreed to.

In the Assembly, N. S. Wales, on October 11, Mr. Melville moved:—1. "That a Select Committee be appointed, with power to send for persons and papers, to inquire into and report upon the practice and regulation of medicine and surgery." 2. "That such committee consist of Dr. Ross, Mr. Abigail, Mr. Day, Mr. Gale, Dr. Wilkinson, Mr. Allen, Mr. Fletcher and the mover." The motion was agreed to.

In the Assembly, N. S. Wales, on October 11, Mr. Wall, without notice, asked whether the attention of the Premier had been directed to the alarming spread of leprosy at Honolulu and whether any steps had been taken to prevent the disease from spreading to this colony. He was informed by Major Parrott, who had recently visited the place, that out of 16,000 inhabitants 1000 of them were isolated on an island with the disease. Sir Henry Parkes said his attention had not been directed to the circumstance. He admitted that the presence of so terrible a disease in any part of the world was objectionable, and he would make enquiries on the matter.

IN THE Legislative Council of South Australia, on October 11, a report was laid on the table showing that

Professor Watson had been experimenting for the purpose of propagating scab disease amongst rabbits. Professor Watson succeeded, in April last, in landing two diseased rabbits from Germany; these soon communicated the disease to other clean rabbits that were put in the cage with them. Since the rabbits arrived the disease has taken about three months before the animal dies. He states that, in Europe, cattle and sheep are in no way infected by the disease, which is peculiar to the rabbit.

UNIVERSITY INTELLIGENCE.

THE Melbourne University Council, at a meeting held on October 10, came to a decision respecting the question of mixed *versus* separate classes for female medical students. A number of proposals were submitted and negatived. Eventually Dr. Cutts suggested that separate dissecting room and separate hospital instruction be provided for female students. This, he believed, would remove all inconveniences which could not be obviated by the exercise of a little tact and common sense. The course of instruction, theoretical and practical, is to be in every respect the same as for male students. It is stated that the additional cost will be about £1000 a-year. Dr. Cutts' proposal was agreed to by 8 votes to 4.

THE authorities of the Melbourne University having enquired if the managers of the Alfred Hospital, Melbourne would establish a separate clinical school for female students, a counter enquiry was made as to the number of such students likely to attend. In reply, the registrar stated that the number of ladies likely to attend the classes would be seven. It was resolved to refer the question of the admission of lady students together with the correspondence on the subject, for the opinion of the Hon. Medical Staff of the institution.

THE Senate of the University of Sydney have appointed the following gentlemen to act with the lecturers in the faculty of medicine in conducting the annual examinations:—Medicine, Dr. McKay; surgery, Sir Alfred Roberts; midwifery, Dr. Sydney Jones; medical jurisprudence, Dr. McLaurin; psychological medicine, Sir Alfred Roberts; materia medica, Dr. Bennett, Dr. Renwick; pathology, Dr. Renwick.

PUBLIC HEALTH.

DURING the year 1886, not less than 523 persons died from typhoid fever in Victoria, or 5·30 per 10,000 of the population; in Melbourne and suburbs alone, 297 deaths from typhoid, or 8 per 10,000 of the population, were recorded during the same period, and during the first six months of the present year 281 fatal cases have occurred in Melbourne and suburbs, or 7·56 per 10,000 of the population, the average for the last nine years being 7·30.

DURING the year 1886, the total mortality due to diarrhoeal diseases in Melbourne and suburbs amounted to 598 cases.

THIRTY cases of diphtheria, of which eighteen proved fatal, were reported to the Central Board of Health of Victoria during the month of October.

DIPHTHERIA is also very prevalent at Ballarat (Vic.); where five fatal cases occurred within a few days.

MEASLES and scarlet fever are prevalent in Sandhurst (Vic.), and the Quarry Hill State School has been

closed for a fortnight, owing to an outbreak of measles amongst the pupils.

THE Kew State School, near Melbourne, was, on the recommendation of Dr. W. B. Walsh, the local Health Officer, closed for a fortnight from October 25, on account of a local epidemic of measles.

MEASLES of a mild form are very prevalent amongst the children attending the public schools in Sydney, and suburbs, especially at Waterloo, where the percentage of absentees is about 60 per cent.

TYPHOID fever has been prevalent at Taroom (Qu.), on the Dawson River, 343 miles N.W. of Brisbane; two deaths from this disease occurred within three days.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Macdonald, Roderick, M.B. Glas., 1884; M.S. Glas., 1884.
Bray, Percy Dean, M.R.C.S. Eng., 1886; L.S.A. Lond., 1884.
Hamilton, John Harry, L.R.C.P. Lond., 1882; L.R.C.S. Edin., 1880.

For additional registration:—

Matheson, Murdoch, F.R.C.P.S., Kingston, Canada, 1876; M.O.P.S. Ontario, 1887.

NEW ZEALAND.

Charlton, Clifton, M.B. et Ch.M., Edin.
Robertson, Ernest, M.B. et Ch.M. 1886, M.D. 1887, Edin.; M.R.C.S. Eng. 1886.

QUEENSLAND.

Bindon, William Vereker.
Magill, Martin, M.B. et Ch.B., Melb., 1887.
Thornton, Philip, M.R.C.S. Eng., 1872; L. 1873, M. 1879, R.C.P. Edin.; L.S.A. Lond., 1870.

TASMANIA.

Harvey, Walter Anstice, M.R.C.S. Eng., 1864; M.B. Lond., L.R.C.P., Lond., 1864.
Bennie, John Taylor, M.D. Mich. Coll. of Med., U.S.A., 1884.

VICTORIA.

Sisco, Natale, M.D. Naples, 1885.
Nercott, William Boyle, M.R.C.S. Eng., 1848.
O'Brien, John William, M.B. et Ch.B. and Qual. State Med. Dub., 1886; L. 1886, F. 1887, R.C.S. Irel.
Noyes, Alexander Wellesley Finch, M.R.C.S. Eng., 1886; L.R.C.P. Lond., 1886; L.S.A. Lond., 1886.
Roberts, Shirley, M.R.C.S. Eng., 1887; L. et L. Mid. K.Q.C.P. Irel., 1887.
Wynne, Joseph Gillis, L.A.H. Dub., 1883; L. et L. Mid. R.C.P. et R.C.S. Edin., 1884.
Bean, Harold Knowles, M.B. Edin., 1880.

Additional qualifications registered:—

Connor, Samuel, M.D. et Ch.B. Melb., 1887 (a.g.).
Kilpatrick, William, Ch.B. Melb., 1887.

MR. L. BRUCK, of 35 Castlereagh-street Sydney, has just received a supply of *Esorine Sulph.*, at 12s. 6d. per tube containing 15 grains.

WE are requested to state that any medical practitioner who desires to try any of Burroughs, Wellcome and Co.'s preparations can obtain one of their elegant specimen cases, free of charge, upon application to the Publisher of this journal, or to Mr. W. Shepperson, the Australian representative of that firm, whose office is in Messrs. Elliott Bros.' buildings, Sydney.

MEDICAL APPOINTMENTS.

Breton, Henry, M.D. Edin., to be Public Vaccinator for Yelta, Vic.
Buckby, Arthur Grey Hedlridge, L.F.P.S. Glas., to be Public Vaccinator for the district of Mercury Bay, N.Z.
Cottew, Arthur Atwood, L.R.C.S. Irel., L.R.C.P. Edin., to be Hon. Surgeon of the Riversdale Rifle Volunteers, N.Z.
Courtenay, John Hoysted, M.K.Q.C.P. Irel., L.R.C.S. Irel., L.R.C.P. Lond., to be Health Officer for City of Collingwood, vice J. B. MacInerney, resigned.
Falles, Frederick George, M.R.C.S.E., to be Government Medical Officer and Public Vaccinator for the district of Cassilis, N.S.W.
Fitzgerald, Michael Edward, L.R.C.S. Irel., L.K.Q.C.P. Irel., to be Government Medical Officer for Springsure, Qu.
Grant, Andrew, M.B. et Ch.M. Aberd., to be Public Vaccinator and Health Officer for the district of Minyip, Vic., vice Dr. Schiel, resigned.
Groves, Henry Joseph Firth, L.R.C.P. Lond., M.R.C.S.E., to be Government Medical Officer and Vaccinator the district of Broken Hill, N.S.W.
Gurdon, Edwin John, L.R.C.P. Edin., M.R.C.S.E., to be Health Officer for shire of Ballarat, Vic.
Haynes, Abraham, L.R.C.P. et R.C.S. Edin., to be Public Vaccinator at Myrtleford, Vic.
Hodgson, Thomas, M.B. et Ch.B. Melb., to be Public Vaccinator at Sunbury, Vic.
Horn, Tudor, M.R.C.S.E., to be Public Vaccinator at Dimboola, Vic., vice Dr. Hayden, resigned.
Hudson, James, M.R.C.S.E., M.B. Lond., to be Public Vaccinator for the Nelson district, N.Z.
Kilpatrick, William, M.B. et Ch.B., Melb., to be Public Vaccinator at Yarra Yarra, Vic.
Lang, William Henry, M.B. et Ch.M. Edin., to be Public Vaccinator at Wahgunyah and Rutherglen, Vic., vice Thomas Loughrey, M.B. et Ch.B., removed.
Perkins, Alfred Temple, M.R.C.S.E., L.R.C.P. Ed., to be Public Vaccinator for the Waverley district, N.Z.
Pooler, Edward Leslie, M.D. et Ch.M. Dub., to be Medical Officer to attend to the destitute poor and aborigines for the district of Quorn, S.A.
Queely, John Eugene St. George, L.S.A., Lond., L.A.H. Dub., to be Government Medical Officer at Marytown, Qu.
Reid, George Marr, M.D. Edin., M.R.C.S.E., L.R.C.P. Lond., to be Public Vaccinator at Birregurra, Vic.
Scantlebury, George James, L.R.C.P. et R.C.S. Edin., L.F.P.S. Glas., to be Health Officer for shire of Ripon, E.R., Vic.
Stevenson, Bernard, L.R.C.P. et R.C.S. Edin., to be Public Vaccinator at Healesville, Vic.
Wynne, Joseph Gillis, L.R.C.P. et R.C.S. Edin., to be Public Vaccinator for Apollo Bay and Irrewillipi, Vic., vice Dr. C. F. Porter, resigned.

HYDE PARK.—To let at beginning of year, First-class Consulting Room and use of Waiting Room.
Apply, Mr. Hallam, Chemist, College-street, Sydney.

BIRTH.

MITCHELL.—October 25, at Narrandera, N.S.W., the wife of James Mitchell, M.B. et Ch.M., of a daughter.

PUBLICATIONS RECEIVED.

Stricture of the Urethra: Its diagnosis and treatment facilitated by the use of new and simple instruments. With original wood engravings. By E. Distin-Maddick, F.R.C.S. Edin., late Surgeon Royal Navy. London: Ballière, Tindall and Cox, 1887.

Experimental Researches in Artificial Respiration in Stillborn Children and allied subjects. By F. H. Champneys, M.A., M.B. Oxon., F.R.C.P. London: H. K. Lewis, 1887.

Contributions to Public Health: By George W. Cole, L.R.C.P. Edin., &c., Hon. Visiting Physician to the Wellington Hospital, Wellington (N.Z.) Lyon and Blair, 1886.

REPORTED MORTALITY FOR THE MONTH OF SEPTEMBER, 1887.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Bronchitis.	Pneumonia.
N. S. WALES.														
Sydney	135,000	336	114	38	...	2	3	1	8	...	18	5	6	5
Suburbs	200,000	803	220	89	1	1	4	...	5	5	24	14	14	14
NEW ZEALAND.														
Auckland	35,965	63	19	6	...	1	1	...	...	...	3	1	5	...
Christchurch	15,684	44	15	4	...	...	1	...	...	...	1	1	...	...
Dunedin	24,233	38	22	2	...	...	2	...	...	...	2	4	...	2
Wellington	26,956	80	42	17	...	...	1	1	2	...	2	4	6	4
QUEENSLAND.														
Brisbane	32,571	125	31	16	} ...	...	5	1	4	7	7	1	5	8
Suburbs	41,082	229	63	32										
SOUTH AUSTRALIA.....	309,820	896	253	71	...	1	5	1	4	5	35	23	11	10
Adelaide	42,904	101	54	13	...	...	1	...	1	...	9	6	3	1
TASMANIA.														
Hobart	31,151	96	31	7	...	...	...	...	3	...	5	7	...	1
Launceston	19,531	68	20	4	...	...	1	...	...	...	1	...	2	3
Hospitals, Asylums, Gaols, &c. .	1,260	...	37	...	...	...	...	...	...	...	...	...	...	...
Country Districts.....	89,080	...	...	...	...	...	...	...	...	...	...	...	...	...
VICTORIA.														
Melbourne	69,774	160	92	} 156	4	...	15	1	7	7	78	47	34	33
Suburbs	275,606	1,141	461											

METEOROLOGICAL OBSERVATIONS FOR SEPTEMBER, 1887.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum	Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.		Depth.	Days.		
							Inches			
Adelaide—Lat. 34° 55' 33" S. ; Long. 138° 36' E. ....	...	79.2	54.8	40.5	29.874	...	...	...	...	...
Auckland—Lat. 36° 50' 1" S. ; Long. 174° 49' 2" E.	122.2	63.2	53.4	40.2	...	...	4.180	19	74	...
Brisbane—Lat. 27° 28' 3" S. ; Long. 153° 16' 15" E.	143.1	80.7	63.2	44.5	30.034	...	1.921	17	64	W.
Christchurch—Lat. 43° 32' 16" S. ; Long. 172° 38' 59" E.	136.7	73.2	47.3	28.6	...	...	1.621	14	73	...
Dunedin—Lat. 45° 52' 11" S. ; Long. 170° 31' 11" E. ....	...	...	...	...	...	...	...	...	...	...
Hobart—Lat. 42° 53' 32" S. ; Long. 147° 22' 20" E. ....	...	65.2	49.3	34.2	29.738	...	3.113	17	80	...
Launceston—Lat. 41° 30' S. ; Long. 147° 14' E. ....	...	64.2	49.7	30.2	29.791	...	4.12	20	73	...
Melbourne—Lat. 37° 49' 54" S. ; Long. 144° 58' 42" E. ....	...	73.1	51.8	35.2	29.834	...	2.71	19	...	...
Sydney—Lat. 33° 51' 41" S. ; Long. 151° 11' 49" E. ....	...	72.6	57.7	44.1	29.961	...	1.57	10	63	W.
Wellington—Lat. 41° 16' 25" S. ; Long. 174° 47' 25" E.	125.5	63.2	50.9	37.5	...	...	3.700	24	78	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES:

ELECTRO-MAGNET OPERATION ON THE EYE.

By B. SCHWARZBACH, M.D., &c.

MR. J. ROSE, age 33, an engineer, living at 3 Brandon-terrace, Darlington, came to me on the evening of Nov. 7th, stating that a piece of steel had flown into his right eye a few hours previously. The piece flew off a sledge-hammer, while he was working at a fuller. The eye-ball looked only slightly irritated; pupils normal; in the inner-upper quadrant of the sclerotic, just outside the line of the ciliary body, the mark of a hurt was visible, but no gaping of a wound. Patient just counted fingers at six feet distance; field of vision was apparently clear, but the ophthalmoscope proved an equally diffused "haziness" in the vitreous body, so as to obstruct the papilla optica from observation. No foreign body was visible until after the dilatation of the pupil; then the shining reflex of a large piece of metal was plainly discernable with the naked eye. By the aid of the ophthalmoscope its situation could be ascertained to be in the centre of the lower half of the vitreous body, floating, as it were, not far behind the crystalline lens. No inter-ocular hæmorrhage could be seen; the tension being equal at both eyes. The very force of the hurt (the metal striking the bulbus with its pointed part) closed the opening in the sclerotic as suddenly as it was made, and prevented the escape of any vitreous matter.

The injury being of great seriousness, the removal of the foreign body from the interior of eyeball was imperative. If not removed it not only would with certainty destroy the sight of the injured organ, but through an irritation of the ciliary body, might also produce a sympathetic cyclitis in the other eye.

As the case seemed to me to be exquisitely adapted for the application of the electro-magnet, I determined to use it. In fact, no other operation seemed possible to remove the metal without destroying the eyeball itself. With the kind help of Dr. MacLaurin I operated on the morning of the day after the injury (Nov. 8), as follows:—The injured organ was well disinfected with a sublimate solution (1-5000) and several drops of a 2 per cent. cocaine lotion were applied at intervals of five minutes. Patient was lying horizontally on a couch, but no chloroform was given. The lids were separated in the customary manner with a lid elevator, and after steadying the bulbus with a fixation forceps, a rather bold

opening was made with a large iridectomy lance in the inner-lower part of the sclerotic, avoiding the ciliary body. Hirschberg's electro-magnet, connected with a bottle element, was carefully, with its heavy end, introduced through the opening into the interior of the eye-ball. A distinct "click" was heard (or perhaps more felt by me than heard) indicating that the metal had flown on to the magnet. But on withdrawing the latter the former was stripped off again on account of the narrowness of the wound. This happened four times—each time the magnet attracted the metal inside the eye-ball, but was unable to retain it when passing the opening. I found it therefore necessary to enlarge the wound with bended scissors, its whole length being now about $\frac{1}{4}$ of an inch. Without any further difficulty the metal was then removed by the magnet. After again disinfecting the eyeball, Grafe's bandage was adjusted. The whole operation caused no loss of blood, and only the loss of two or three drops of vitreous matter. The extracted piece was 5 millimeter long, nearly 3 millimeter broad at its broadest part, and about $\frac{1}{2}$ millimeter thick, thus explaining its "floating" capacity.

On the following day the eye did not look unusually irritated and the wound was nicely closed. But 24 hours later a small yellowish rim covered the part where the opening was made; pericorneal injection noticeable and tearing, but no chemosis of the conjunctiva. I disinfected the eyeball with a strong sublimate lotion (1-1000), and applied a firm pressing bandage. On the very next day the wound looked again healthy and the irritation was subsiding. After eight days a green flap was substituted for the bandage, the organ being at that time without abnormal congestion, pupil and tension also normal. By re-introducing the patient to Dr. MacLaurin, we found that he easily counted fingers at 20 feet, and could read Sn. No. 5. The vitreous body was clearing rapidly and allowed, after two more days, the reading of ordinary newspaper print. Patient was then discharged and wrote to me on Nov. 25: "I am very happy to say my eye is almost as well as ever again."

Concluding, I may state that the whole case was treated policlinically—patient being neither confined to his bed, nor to a dark room. I was induced to publish the case in the belief (sustained by the belief of other medical men) that it contains the first electro-magnet operation of its kind performed in Sydney.

151 Macquarie-street, November, 1887.

REMARKABLE CASE OF FÆCAL ACCUMULATION.

READ BEFORE THE MEDICAL SECTION OF THE
ROYAL SOCIETY OF N.S.W.

By RALPH WORRALL, M.D. ET CH.M. QU.
UNIV., IREL.; HON. ASSISTANT SURGEON TO
THE DEPARTMENT FOR DISEASES OF WOMEN,
SYDNEY HOSPITAL.

THE case of fæcal accumulation which I bring under your notice this evening exceeds in size (considering the age of the patient) any which I have been able to find recorded in the literature at my disposal.

Annie L—, a delicate, strumous-looking child 13 years old, but in appearance not more than 10, was brought to me in September, 1887, suffering from an enlargement of the abdomen, which had been first noticed 2 months previously, and which had steadily increased since. She had had no illnesses of any consequence; had enjoyed fair health and her mother thought her bowels were regularly moved.

On examination, a solid tumour, neither painful nor tender, was found to fill the whole abdomen except portions of the left hypochondriac and left lumbar regions, having its greatest prominence at a point to the left of the umbilicus. It was of stony hardness, with a surface nodulated and irregular. Above it appeared to touch the liver, and below it dipped deeply into the pelvis, from which it seemed to have origin. Apparently the colon bounded it laterally, the flanks being quite clear with no evidence whatever of ascitic fluid. The heart was displaced upwards and liver dullness was quite absent in front, although the lower margin was apparently felt below the ribs. This was accounted for by supposing that perhaps intestine had become pushed upwards. The tumour could be moved slightly from above down, and fairly well from side to side. The abdominal and chest veins were considerably enlarged and the right thigh and leg were swollen and cedematous.

The abdomen measured 27 inches around the most prominent part. The urine was normal.



Front View.



Side View.

She was admitted into the Sydney Hospital, and although the bowels were moved several times daily a dose of liquorice powder and an enema were given before making an examination under chloroform. It was then found that there was still some faeces in the rectum which prevented a thorough examination of the pelvis. More aperients were ordered and for the next ten days there was constant diarrhoea, the motions being horribly offensive. The temperature was about 101° each night, and the pulse 130, very weak. Her condition seemed so bad, that I doubted if she would live until the day of operation. After consultation with my colleagues it was decided to make an exploratory incision, the general opinion being that the tumour would probably prove malignant. The day but one before operation, I again examined the abdomen and found no change, but when the patient was put on the operating table more than half the tumour was seen to have disappeared. The hard mass in the pelvis was, however, unaltered, and acting on the supposition that this was the *fons et origo mali* which had caused the faecal accumulation now dispersed by the aperients and enemata, I proceeded to open the abdomen. On doing so, what appeared to be a large cyst, fluid above and solid below, was found to occupy almost the entire abdominal cavity. I attempted to puncture the fluid portion with a small Wells' trocar, but finding this difficult I extended the incision upwards and introducing my hand discovered that the supposed cyst was the ascending colon enormously hypertrophied and dilated. The coccum lay in the pelvis and contained an extremely hard mass of faeces.

I could find no liver in its usual situation, but what appeared to be that organ occupied the left hypochondriac region. Thinking it wiser to avoid further manipulation of the viscera I closed the wound by 15 wire sutures, fastened with Aveling's coil and compressed shot.

There was slight vomiting and considerable pain on recovering from the ether, for which morphine gr. $\frac{1}{2}$ hypodermically, was administered.

The day after operation she expressed herself as feeling quite well and very hungry, although appetite had been quite absent before operation. Her only trouble was that the bowels were acting almost continuously, apparently having received a decided stimulus by the operation.

Nothing was given except beef tea, to which a little beef peptonoids had been added.

The temperature, which had been 100° and 101° in the evenings for the week she had been in hospital before operation, was normal for 6 days afterwards and the pulse fell from 136 to 106.

From the sixth to the tenth day both temperature and pulse were raised, caused probably by luxuries surreptitiously administered by too kind friends.

The wound was first dressed on the 6th day, and as it had firmly united without a drop of pus the sutures were removed. The abdomen was concave, not a vestige of the tumour remaining. The patient was discharged on the 14th day in sound health.

Some philosopher of our profession has said that "mistakes are not faults unless they are concealed and then they become crimes." Spencer Wells, and other leading abdominal surgeons have recorded cases in which they opened the abdomen only to find a condition similar to that which I have just related, and surely nothing could be more misleading than the signs in this case. The youth of the patient disallowed the suggestion that here might be defective innervation leading to intestinal paralysis, and her cachectic appearance (represented in the illustrations above) strengthened the belief that the rapidly growing tumour of stony hardness which filled her abdomen was malignant. She owes her life to my error, for if I had not admitted her to the hospital for operation, she could not possibly have lived a month. In the treatment of cases of faecal accumulation I would suggest a diet which would leave no residuum, such as Cornick's Beef Peptonoids, and the cautious use of massage in addition to enemata, bearing in mind that stercoraceous ulcers are often present, due in part to over distension, and in part to the irritation of the retained faeces.

The case is another proof of the harmlessness and benefit of exploratory abdominal section when performed with due care.

AN EXTENSIVE ANEURISM.

By W. R. CLAY, L.R.C.P., LOND., M.R.C.S.E.,
HOUSE SURGEON, SYDNEY HOSPITAL.

J. F., aged 44, admitted into the Sydney Hospital on September 11th, under the care of Dr. M. J. O'Connor. On admission, the patient complained of general weakness and pain about the left shoulder and left costal margin.

There was a prominent swelling on the back, internal to the left scapula, its upper margin being on a level with the second, and its lower about the eighth dorsal vertebra, the length being about seven inches. Laterally, it extended from half an inch to the left of the spinous processes, outwards for a distance of five inches. The scapula was pushed outwards, and elevated from the ribs, and its vertebral border could not be clearly defined. There was a strong pulsation felt over the whole of the swelling, which was not

expansive in character, and was most marked at the lower part. The left shoulder was elevated with each pulsation, and the patient's head moved slightly also. The swelling was fixed to the chest-wall, but the skin, although very tense, could be freely moved over it. It was semi-fluctuating to the touch, and could not be emptied. The veins of the back, and left arm, were enlarged. Radial pulses equal in force and time. Percussion note dull over the left side of the back. No murmur could be detected, but the cardiac sounds were heard loudly all over. In front there was no dullness; the breath sounds were very weak, and the cardiac sounds loud. There were no signs of pressure.

The tumour rapidly increased in size, and the pulsation became stronger. The left pulse then became very weak, and for ten days before the patient's death he had frequent attacks of violent dyspnoea, the pulsation then becoming so marked that all the upper part of the body seemed to take part in it. There were also signs of pressure of the left recurrent laryngeal nerve.

Patient died somewhat suddenly on October 12.

P.M.—On opening the thorax a large quantity of fluid blood was apparently filling the left side. The apex of the heart was pushed about three inches to the right of its normal position. Left lung completely collapsed, and right one partially so. A large aneurism almost filled the upper two-thirds of the left chest.

Heart normal. The first and second parts of the arch of the aorta slightly atheromatous. From the outer side of the third part of the arch the aneurism had developed, it extended from the first to the eighth dorsal vertebra, and was somewhat oval in shape. The left sides of the bodies and transverse processes of the six upper dorsal vertebrae were much eroded, the third and fourth being half absorbed. The third rib was eroded, and the bone had apparently just broken, about four inches of the fourth rib, and six of the fifth and sixth were completely absorbed, the upper border of the seventh rib was also eroded.

Through the breach in the chest wall the aneurism had extended, and ploughed up the tissues from the first to the tenth ribs, and laterally to the axilla.

The wall of the aneurism was composed of all the coats of the vessel in front, but it soon got thin. The vertebrae of course formed the posterior wall of the intra-thoracic portion; the extra-thoracic portion had no definite wall.

The aneurism contained a small amount of laminated clot within the chest, and outside it was full of soft clot. The rupture was small, and situated at the eroded end of the sixth rib.

A CASE OF TYPHOID, TREATED BY COLD BATHS.

By F. E. HARE, M.B., M.R.C.S.E., RESIDENT MEDICAL OFFICER, BRISBANE HOSPITAL.

J. C., æt. 23 years, a powerfully-built Irishman, was admitted into the Hospital on September 16. He gave the following history.—Having felt in his usual health during the early part of the 12th inst., he was taken about 5 p.m. with malaise, nausea, and severe frontal headache. On the two following days, his symptoms were more severe, and in addition he suffered from backache. On the 15th, about 7 p.m., he had a rigor, followed by intense feeling of heat, thirst, etc. On the 16th, epistaxis. There had also been a slight, dry cough; no diarrhoea.

On admission his temperature was 102.2° F.; pulse 108, large and soft; tongue presented a broad, dry and brown band down the centre, whilst the edges and tip were red and moist; sordes on teeth and tip; no spots or abdominal symptoms of any kind; mentally, quite clear. As the bowels were confined, he was ordered five grains of calomel, and cold sponging every two hours.—Diet to consist of milk, 3 pints; beef tea, 1 pint; with iced water *ad lib.* During the night his temperature varied between 105° and 108°, the sponging having little or no effect upon it. He was restless and slept badly.

Sept. 17.—Has had four large, loose stools. 11 a.m.—T. 106°. Ordered to have a bath (T. 68° F.) of fifteen to twenty minutes duration, according to the amount of shivering produced, whenever the temperature in the rectum reached 102.2°. For the next five days I have given a detailed account of each bath, showing the effect produced on the temperature and pulse rate. The temperature, which is in every case that of the rectum, is taken immediately before and thirty minutes after each bath, the pulse being taken at the same time. The varying temperature of the bath water is noted in the second column—

Date.	T. of water	Time.	T. before bath	Pulse before bath	Duration of bath	30m. after bath	
						Temp.	Pulse
Sept. 17	68° F.	11.30 a.m.	106°	99	15m.	102°	86
"	"	3 p.m.	104.8°	100	15m.	101°	90
"	"	6 p.m.	105.6°	108	20m.	100.8°	86
"	"	9 p.m.	105°	104	20m.	102°	92

Slept soundly between the baths; as the temperature, though high, appeared easily reducible, he was ordered cold sponging during the rest of the night, also to have quinine gr. xl. at 10.30 p.m.

Sept. 18.—Baths resumed this morning, as the reduction of temperature caused by the

sponging was insignificant—

Sept. 18	68° F.	7 a.m.	104.2°	106	20m.	102°	80
"	"	10 a.m.	103.4°	100	30m.	101.8°	78
"	65° F.	1 p.m.	104°	102	20m.	100.6°	72
"	"	4 p.m.	108°	100	20m.	100.4°	76
"	"	7 p.m.	106.6°	116	20m.	102°	88
"	"	10 p.m.	106°	108	20m.	102°	92

Had three very loose, typhoid stools. Diet—3 pints milk only, predigested with "zymine." To have quinine gr. L. and be sponged during the rest of the night.

Sept. 19.—Reduction of temperature from sponging only about .5°. Baths resumed—

Sept. 19	65° F.	7 a.m.	104°	100	20m.	101°	88
"	"	10 a.m.	102.8°	108	20m.	100.6°	86
"	"	1 p.m.	102.4°	100	20m.	100.8°	88
"	"	3 p.m.	101°	96	no bath	—	—
"	"	4 p.m.	105.6°	108	20m.	101°	98
"	"	6 p.m.	101.8°	100	no bath	—	—
"	62° F.	7 p.m.	103°	104	20m.	100.6°	90
"	"	9 p.m.	103°	108	20m.	101°	98
"	"	11 p.m.	101°	100	no bath	—	—

Tongue still dry and brown as on admission. Has had two loose, typhoid stools. At 7 p.m. he was ordered to have a bath (62° F.) every two hours, should the temperature reach 102.2. Same diet with 4ozs. whiskey—nourishment to be administered during the bath.

Sept. 20	62° F.	12 a.m.	104°	104	20m.	101°	96
"	"	2 a.m.	101°	99	no bath	—	—
"	"	3 a.m.	103.8°	102	20m.	101°	98
"	"	5 a.m.	102.8°	100	17m.	100.8°	98
"	"	7.30 a.m.	104°	106	20m.	101°	92
"	"	9.10 a.m.	104.4°	104	20m.	104°	106
"	"	11.45 a.m.	104.4°	104	27m.	103°	100
"	"	1.30 p.m.	104.4°	104	30m.	103°	98
"	"	3.30 p.m.	104°	108	30m.	104°	99
"	"	6.30 p.m.	106°	112	30m.	105°	100
"	59° F.	9.30 p.m.	106°	106	30m.	103.4°	94
"	"	11.30 p.m.	104.4°	104	30m.	103.4°	98

Had one loose stool. Has tympanites. To have a large ice bag kept constantly filled applied to abdomen. Whisky increased to 6ozs., to have quinine gr. xl. at 10.30 p.m.

Sept. 21	59° F.	1.30 a.m.	104.4°	104	27m.	103.2°	98
"	"	3.30 a.m.	104.4°	106	30m.	103.2°	98
"	"	5.30 a.m.	104.4°	104	27m.	102.4°	94
"	"	7.30 a.m.	102.8°	103	20m.	101.4°	100
"	"	10 a.m.	102.8°	112	30m.	100.8°	104
"	"	12.30 p.m.	102.4°	104	30m.	101°	100
"	"	2.30 p.m.	103.2°	112	35m.	102°	108
"	"	4.30 p.m.	105°	114	35m.	104°	112
"	"	7 p.m.	104.4°	112	30m.	103.2°	106
"	"	9 p.m.	103.8°	106	30m.	102.6°	104
"	"	11 a.m.	103.8°	106	30m.	101.6°	98

Still has sordes on teeth and lips; tongue remains dry and brown down the centre, while the tip and edges become moist after each bath. Gurgling in right iliac fossa, with tenderness; tympanites less than yesterday; bowels have not been moved; one or two spots. Ice bag continued, whisky increased to 8ozs.

Sept. 22.—Had during the 24 hours 11 baths (T. 59° F.) of an average duration of 34 minutes; tympanites much less; passed one loose, typhoid stool, with a large amount of flatus; several more typical spots appeared to-day; pulse more sustained.

Sept. 23.—Had 12 baths (T. 59° F.) lasting on an average 31 minutes each; tongue remains dry; fresh spots; no stools.

Sept. 24.—Had 8 baths (T. 59° F.), average duration 30 minutes; 2 stools, very slightly formed; pulse-rate attained its maximum, 132; whisky increased to 10ozs.

Sept. 25.—Had 8 baths (T. 59° F.), average duration 25 minutes; tongue remains dry, but is quite soft, protrusion rather faulty; many fresh spots; no tympanites or tenderness of the abdomen, which is quite flaccid and retracted. He was slightly delirious this morning for the first time, but this passed off during his 11 o'clock bath (and never reappeared); one stool. To omit ice bag.

Sept. 26.—Had 6 baths (T. 68° F.), average duration 16 minutes; pulse longer; one stool.

Sept. 27.—Had 4 baths (T. 68° F.), average duration 15 minutes; one stool, slightly formed; spots still coming out; one egg, beaten up, added to diet.

Sept. 28.—5 baths, average duration 9 minutes; ordered to have a short bath every 3 hours should the temperature in the rectum register 101° F. Bowels not open. Whisky reduced to 8ozs.

Sept. 29.—5 baths, average duration 5 minutes. Bowels not open.

Sept. 30.—4 baths, average duration 5 minutes; one loose stool.

Oct. 1.—2 baths, average duration 5 minutes; tongue softer, brown coating coming off in flakes. Whisky reduced to 6ozs.

Oct 2.—2 baths, 5 minutes each; tongue perfectly clean and moist; protrusion perfect; lips and teeth clean; heart sounds distinct; systole not appreciably shortened. Whisky reduced to 4ozs.; another egg added to diet.

Oct. 3.—1 bath of 5 minutes.

Oct. 4.—1 bath of 5 minutes. Predigested food stopped. Diet, 3 pints milk, 1 pint beef tea, and two eggs beaten up.

Oct. 5.—Convalescence established. Cease whisky.

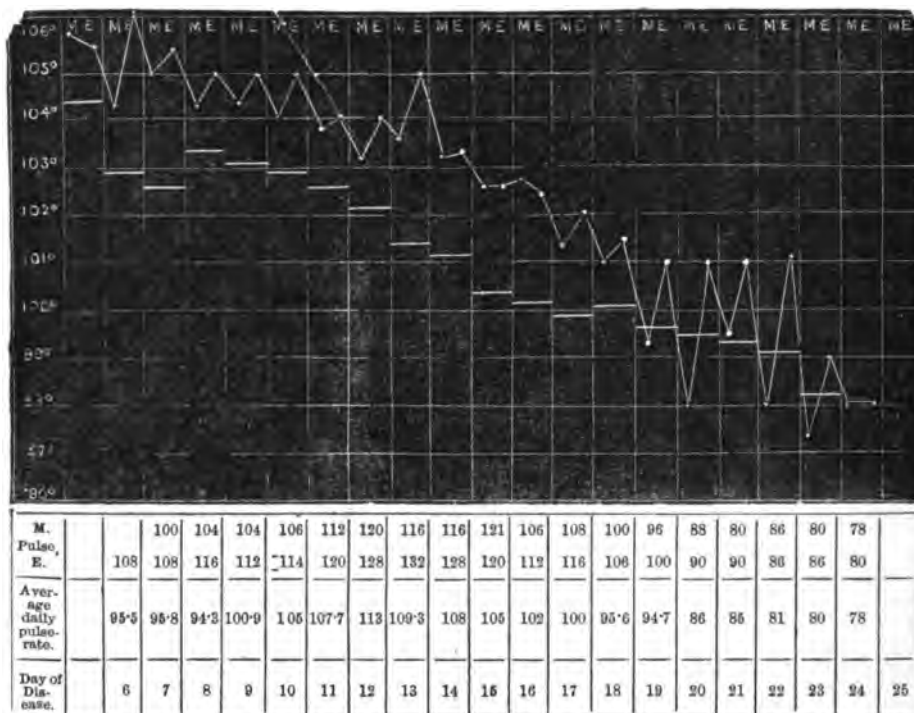
Oct. 11.—Got up for the first time, and was able to stand without assistance. The only drugs given besides the initial dose of calomel were the three doses of quinine. The first (40 gr.) appears to have had little or no effect, the second (50 gr.) given at 1 a.m. on the 19th produced its maximum result between 1 and 3 p.m., while the

third dose caused no appreciable fall in the temperature. The total number of baths was 107, in 18 days.

In the appended chart the zig-zag shows the course of the temperature, as determined by morning and evening observations. The lower horizontal lines indicate the mean daily temperature calculated from the numerous observations taken before and 30 minutes after the baths. The

mean daily pulse-rate is similarly arrived at.

Of course these averages do not in either case represent the actual daily mean, as might be determined by an indefinite number of observations, each day. The true mean would certainly be a little higher. They serve, however, to show the tendency of the treatment rather than its actual effect.



I have been induced to publish this case because it clearly illustrates most of the effects of cold bathing on typhoid, which those who have experience in this method of treatment almost constantly find. The most important are the absence of complications, especially of the pulmonary system; the check on the progressive cardiac debility; the lessening of tympanites and diarrhoea, the effect in this instance being always greatly aided by the local application of ice to the abdomen; the great freedom from nervous symptoms and delirium, and the sound sleep which, although constantly broken, amounts to a much greater total than in cases otherwise treated. I should here say, that with the exception of a little alcohol, immediately before, the patient had all his nourishment and stimulants administered to him during the bath, so that the intermediate time was wholly devoted to sleep.

As is usual in cases so treated appetite returned

early and convalescence was remarkably rapid. The only symptom which proved an exception to the rule was the persistently dry condition of the tongue. It is usually one of the first of the typhoid phenomena to disappear under systematic bathing.

There can be no doubt that the reason why the German treatment of typhoid has attracted so little notice among English and colonial physicians is that it has been regarded from a totally wrong point of view. It is essentially a prophylactic, and as such must be systematically employed from the beginning of the fever and before asthenic symptoms or complications have appeared. So applied it is absolutely free from danger. On the other hand, to use it, as has most frequently been done in England, as a sort of forlorn hope, late in the disease, on a patient worn out by prolonged pyrexia, is not only as a rule useless, but is never free from immediate

danger. Systematic antipyresis by cold water will most frequently prevent the acute fatty degeneration of the heart which occurs in fevers, just as the avoidance of sedentary and indolent habits might have prevented some of the cases of chronic fatty degeneration of the heart which occur late in life, but it would be almost as logical to recommend violent exercise as a method of cure in the latter instance, as to commence a vigorous application of cold baths to a case of typhoid with advanced cardiac debility.

ABDOMINAL SECTION.

READ AT THE QUEENSLAND MEDICAL SOCIETY,
By J. PENNEFATHER RYAN, L.R.C.S.I., L.K.
AND Q.C.P.I., GYMPIE (QUEENSLAND).

THE title of my paper would seem to indicate that it is my intention to enter into minute detail not only as to the most approved method of performing "Abdominal Section," but also as to the various diseases and lesions in which this proceeding has been found, not merely useful, but absolutely indispensable. My object, however, is not of such an ambitious nature; it is simply to give a few notes of my limited work in the great field of abdominal surgery, with the hope that by so doing I may elicit from those present this evening some account, however brief, of their own labours in the same field.

My first ovariectomy was performed nearly four years ago, with the assistance of the late Dr. Power, then of Maryborough, and of the late Dr. Benson, of Gympie. The tumour removed was a multiple cystoma, being a conglomerate of small cysts and solid growth, the whole weighing about nine pounds. The usual incision having been made and the peritoneum opened, considerable difficulty was met with in delivering the tumour, as from its nature only a small amount of fluid could be evacuated by trocar and canula. I therefore adopted the plan of making a free incision into the tumour and introducing my hand with which I broke up sufficient of the small cysts to permit of its delivery without enlarging my original incision (of $4\frac{1}{2}$ or 5 inches). The only adhesions were omental and separated without much difficulty and with very little hæmorrhage. The pedicle was transfixed by an ordinary pile needle armed with strong ligature silk, securely tied and dropped into the abdominal cavity, which was carefully sponged out before the incision was closed in the usual manner, and the operation thus completed. The dressing simply consisted of salicylated plaster strapping, and a large pad of absorbent wool, the whole secured by a bandage of fine flannel. My patient made an

excellent recovery, and has since given birth to two children, a boy and a girl.

My second case was a most interesting one, and the more gratifying as what was originally only intended to be an exploratory incision resulted in a most radical cure. I intend at a future time to publish notes of this case so shall not enlarge upon it at present, further than to say, that as anticipated from most careful examination the tumour was found so firmly adherent to important pelvic structures that its removal was considered inadvisable in the then state of our knowledge of complicated ovariectomy. This operation was performed with the assistance of Dr. Power, Dr. Harricks, of Maryborough, and Dr. Small, now practising in Geelong. The favourable result may be attributed to the aspiration of the tumour, before closing the abdominal incision, by which tension was relieved and sufficient irritation set up to cause subsequent absorption. My next operation was done on the following day, in the presence of Drs. Power and Small. It was a gastrostomy, combined with tracheotomy and has been fully reported both in the *Australasian Medical Gazette* and the *Lancet*. Suffice it to say that my patient survived the double operation nearly seven-and-a-half months, when an extension of the cancerous growth down the trachea caused death. The fourth case was operated on three weeks after the third, the cyst removed was parovarian, single, containing six pints of fluid, and without any pedicle—this last being a most unfortunate and perplexing condition for any operator, but more especially for one like myself with but a limited experience. Another complication, likewise unexpected in this case, was extensive and firm adhesion to the small intestine, after separating which I was enabled to transfix the base of the cyst and thus form a sort of pedicle, which was duly ligatured after which the cyst was removed and the concluding steps of the operation proceeded with. The recovery was good until about the 12th day when a rise of temperature indicated mischief, which eventuated in a fecal abscess causing much trouble and anxiety for several months, when the resulting fistulous opening closed and the patient made a perfect recovery.

My last ovariectomy was performed on the 19th of last month, with the assistance of Drs. Dunlop and Geddie, both of Gympie. It was the only case with which I have met which was entirely uncomplicated. It was a left ovarian cystoma, consisting of three cysts, the largest of which contained five quarts of blood-stained fluid; the other two were small, one having evidently but recently ruptured into the large cyst. The

recovery was rapid and uninterrupted, and on the 11th day, when I last saw the patient, all sutures had been removed and firm union by first intention had taken place. Thus in the short period of three weeks from first seeing the case it was diagnosed, operated on, and radically cured. I will say nothing as to the preparation or treatment, either before, during, or after the operation of ovariectomy, but will merely refer you to Tait's work on the subject, where you will find full instructions which deal with every complication and condition likely to be encountered. The anæsthetic used in these cases was chloroform supplemented by sub-cutaneous injections of ether sulph. to prevent its possible ill-effects. And I am convinced that this method not only wards off the dangers of heart failure, but actually lessens the tendency to vomiting, which is always of most grave import in abdominal section. I make it a point now to use ether in this way in every surgical operation which is likely to last more than a few minutes, as it inspires an amount of confidence which one cannot otherwise feel in the face of the many accidents which have occurred from the use of chloroform alone.

CROUP AND DIPHTHERIA.

By JOHN REID, M.A., M.D., CH.M. ABERD.

TYPHUS and typhoid were undistinguished at one time, and so were scarlet fever and measles. Frivolous distinctions are to be avoided. The Scotch school has long considered croup to be a local disease. The committee of the Med. Chir. Soc. Lond., 1878, confine croup to laryngeal obstruction, with fever, in children. (Suppt. Ziemssen. Encyc., p. 84.) The causes and connections are summarised, viz. (1) from diphtheritic contagion; (2) foul water, &c.; (3) measles, scarlet fever, independently of diphtheria; (4) membrane may be from acids or foreign body in larynx and throat. It is evident from these and following causes given that the said committee was composed of a sufficiently heterogeneous element to make the term croup wide enough, and still to stick to it as describing a definite disease of many phases. As I believe Engel (Phil. Med. and Surg. Reports, Jan. 14, 1882) to have first put us on a track to leave the realm of conjecture and opinion, I shall note one or two salient points. He gives the usual marks adverted to by Scotch physicians, and adds, "The membrane of croup is soluble in KHO, and hardened by H_2SO_4 , and consists of newly-formed cells, while the membrane of diphtheria is soluble in H_2SO_4 , hardened by KHO solution, and consists of masses of bacteria and cells." I

shall first consider the pathology of the complaint, and quote Peters (Virch. Archiv., lxxxvii, p. 477) inasmuch as it is a simple statement of facts by an able writer. "The vessels, capillaries, and smallest arteries are degenerated in the upper mucous layer; the parenchyma, including cells and ground substance, is also affected, and in a not less degree the lymph vessels and their contents. Hyaline degeneration of the epithelium indicated that it, too, assisted in forming the false membrane. The false membrane consists of a fibrous network, cells of connective tissue, vessel walls, colourless blood corpuscles, pus-cells and micrococci. As to time, hyaline degeneration occurs in the following order: In the epithelium, contents of lymph and blood vessels, vessel walls (media first) and parenchyma. Several days elapse before the last occurs. Micrococci occur in the membrane and lymph and blood vessels." Now, I would say that that description may indicate degenerative stages of a morbid product, for pus can scarcely be considered a necessity. Still we have pretty good evidence to show that, as in scarlatina (see burns and scalds, Newmann quoted) all the elements of the skin are attacked. In croup, like measles (loc. cit.) the attack is chiefly confined to the mucous glands of the windpipe and thyroid gland. Their cells indicate proliferation and inflammatory processes, and in their interior are found micro-organisms. Of course, where the membrane is situated, evidences of inflammation occur, hyaline degenerations, increased vascularity, and so on. But note, in a P.M. of mine (case of croup) this membrane and the thyroid gland are rendered opaque for microscopic examination by acetic acid, even after having been immersed for a few days in bichromate and sulphate of copper solution, while ammonia at once clears up the specimens. The growths on gelatine were different in croup and diphtheria, the organism of croup (micrococcal larger). The croup made a clear fluid and an opaque growth on the gelatine, while the diphtheria caused threads. I will not go further on the micro-organism track, as there are too many different opinions thereabout. The chemistry, however, is quite a different matter. I may say that in the diphtheritic membrane I obtained evidence of lime by oxalic acid. Whether this has anything to do with the chemical reaction or not I cannot say. It will be noted that mucus is hardened by sulphuric acid. Neither pus nor mucus gives the reaction mentioned by Engel for croup, and which I can mention as occurring in cases treated by me. His other chemical reaction has invariably been used by me as a diagnostic point. Notwithstanding the vary-

ing pathology of membranous dysmenorrhœa, Dr. Barnes affirms that the membrane expelled in some cases consists essentially of fibrin and mucus. It has been customary to look on every exudation as diphtheritic, and so we have Bristowe writing of expectoration, "casts of laminated texture and apparently identical with diphtheritic membrane." False membranes occur in the bowel, in the bile duct (Bristowe) and bladder, besides other parts. I regret that I am unable to give their characters so that analogy might be brought to bear on the question. I trust that Dr. Barnes' observation and this brochure will lead to more searching inquiry in all cases in which false membranes are observed to occur. I do not find fault with observations, but with the theories, for "facts are chieftains that winna ding." It will be seen, then, that I hold diphtheria and croup to bear the same pathological relationship as do scarlet fever and measles in their skin action, and that croup is not confined to the larynx, but affects the follicles of the thyroid gland. The pathology is, however, to be helped by clinical observations—neither is complete in itself. Before doing so, however, I would call attention to that inspissated mucus which occurs to persons in tropical climates. The sun's heat acts on the human body. It is not an unknown quantity at home; the inspissated mucus occurs in various irritant states of the system, such as stomach and in fevers. In the case of tropical heat effects, I have already adverted to the state in my notice on drumine, and so need not revert. I may, however, add that this membrane or inspissated mucus adheres so firmly to the mouth and lips as to leave a surface denuded of epithelium on its removal. It is a state similar to this which I believe to exist in croup, and the circumstances which occasion it will assist in elucidating the phenomena of croup. Instead of further dilating on this, I shall give cases of croup as types. K. D., æt., 3, was seen on March 9, 1884. Her mother said that on the 7th, about 4 p.m., she was seized with spasmodic breathing. As she had worms I gave purgative. On the 10th had spasmodic laryngeal breathing, and had parted with large round worm. Temperature was 98·6, and there was slight brown fur on the tongue; cough somewhat croupy. Many small worms came away. At 4 p.m., temperature 101, distinct croupy cough, almost choking; neck tender over thyroid. Blistered with iodine and croton oil. Tonsils and throat were clear; tongue had greyish-brown fur; laryngeal breathing on stethoscopic examination was muffled. 9 p.m. Temperature 100; perspires freely; breathes with difficulty; no vomiting; has been taking aconite, ipecac., and antimony, and inhales carbolic

iodine and camphor with steam without interruption. 11th—Temperature, 10 a.m., 101. Increased ipecac.; breathing very bad; nearly choked at 3.30 p.m., when I was called suddenly, as she was believed to be dying. Breathing loud, stridulous, and frequent croupy cough at 4 p.m. She was immediately put into a blanket bath, which was changed for a dry one. At 8 p.m., tongue clean and moist, reddish epithelium. At 9 p.m., temperature 101, drinks milk; breathes with stridor and difficulty. Ordered Liq. Ammon. Acet., Eth Nit., Ipecac. and Sod. Bromid. 12th—At 11 a.m., temperature 101·2; evening, 101·8. Morning, breathing easier and stronger, less hissing respiration, expectoration pretty free—chemically answers to tests for croup, and microscopically, as mentioned before, as membrane is free from pus. Evening weaker, speech scarcely audible; croupy cough, dry and singing; vomited curdled milk. The rales are sonorous on both sides of the chest, and breathing is difficult. In the morning she had gr. v. calomel. Tongue moist in the morning, dry in the evening, but without fur. Doubt if strength would carry through the night. Ordered V. Ipecac., T. Cinchon. Co. and Sp. Chloroform every hour. 13th—Temperature 100·3. Pulse stronger; chest has occasional rale on both sides; larynx gives harsh breathing, and sound as of a flapping membrane occasionally. Tongue moist, no fur; bowels open twice; thirst less; cough still croupy. I may say that urine was not passed in large quantity, that there was a little albumen and one or two granular casts. Evening, temperature 101·4, pulse stronger, tongue clean and moist, makes more water, sits up. The pharynx is red, a gelatinous substance is on the tonsil, and a greyish stuff is seen loose. (Expectoration?) With strong coughing muco-pus, membrane, and a streak of blood were brought up. Large hyaline ovoid cells were seen. 14th, Morning, Temperature 100·5. Hard stools. Calomel, gr. v. Evening, temperature 102·4. Flannel put next the skin; bowels open three or four times; cough has more ring, less muffled; spasmodic breathing when I called (she was peevish). 9.30 p.m. R. Pot. Bromid. ℥i., Pot. Iod. gr. v., Sod. Salicylic ℥i.; T. Camph. Co. ℥ii. Aquæ Menth. ℥ii. Signa ℥ii, om. hora. Mucous rales in chest; flapping still heard over larynx; tongue, brown in morning, moist in the evening; thirst less. 15th—Temperature 102·5. Purulent expectoration; breathes more easily; larynx almost clear; moist rales in chest; still purged; motions black; urine sp. gr. 1027, faintly alkaline, phosphates abundant; trace of albumen; pus corpuscles and lively bacteria. R. V. Ipecac., T. Cinchon. Co., ʒss., Pot. Iodid ʒss., Pot.

Bromid $\mathfrak{Z}\text{ii.}$, Aq., $\mathfrak{z}\text{iv.}$ Signa $\mathfrak{z}\text{ii.}$, om. hora. Evening temperature 101.2; herpes on lips; makes little water; thirst less; white thick substances, not expectorated, in mouth, roof, &c. 16th—Temperature 99.4. Cough spasmodic, occasionally purulent; expectoration, along with saliva secretion, returning; tongue greyish-brown; conjunctiva somewhat yellow; still spasm in larynx; thirst during the night. 17th—Temperature 99.5. Tongue furred; ordered soda and Epsom Salts with the mixture. 18th—Temperature 100.2. Breathes with slight difficulty; coughed up blood last night; few rales in chest; laryngeal breathing almost pure; R. Acid Sulph. dil., $\mathfrak{z}\text{i.}$ Eth. Chlor. $\mathfrak{z}\text{i.}$, T. Cinchon. Co. $\mathfrak{z}\text{ss.}$, Pot. Bromid. $\mathfrak{z}\text{ss.}$, Mag. Sulph. $\mathfrak{z}\text{ss.}$, Aq. ad. $\mathfrak{z}\text{iv.}$, Signa $\mathfrak{z}\text{ss.}$ 4 times daily. Still inhales. 19th—Slept without fire last night; slight difficulty in breathing; tongue somewhat brown; eats fairly well; bowels regular; urine acid, sp. gr. 1017; no albumen; carbonates. 20th—Temperature 99.2. Tongue, greyish fur; breathes easily. After examining throat against child's will, there was husky cough and impeded rough (stethoscope) breathing; bowels regular. 21st—Not seen 22nd—Temperature 99.2. Tongue somewhat grey; fauces red. 24th—Temperature normal. Tongue moist; slight cough in morning; no stethoscopic result; ordered out; discharged. A. C., $\text{ \hat{a} t. 5 years}$, has had laryngeal catarrh for a fortnight before being seen, on April 8, 1884. This was a joint attendance, and orders were given by my senior. R. V. Ipecac. $\mathfrak{z}\text{ss.}$, Aeth. Nit. $\mathfrak{z}\text{ss.}$, Aq. ad. $\mathfrak{z}\text{ii.}$, $\mathfrak{z}\text{i}$ bis hora and Calomel, gr. iii. immediately. At 5 p.m.—Temperature 100. Tongue moist, grey; bowels open; croupy cough and modified laryngeal breathing. 4th—Repeat mixture. 9 p.m., temperature normal, laryngeal husky breathing more pronounced; shoulders raised; and croupy cough; vomits occasionally; perspires freely; has throughout been subjected to steam from blanket; gr. iii. calomel morning. 5th.—At 11 a.m. I painted over larynx with Liq. Epispasticus. He was then gasping. He died in the afternoon. No false membrane was seen, and expectoration was lost sight of. As the next three cases occurred in the same house, and with the same surroundings—there being an unventilated wooden floor in the house, I must anticipate doubts in the mind of my readers as to accuracy of diagnosis in the first case, and point out that the autopsy was carried out carefully—membranes, &c., examined—and that even to the parents the different symptomatology in the first was very evident. There was not the languor and malaise at the outset, as in the second two. The first, E. H., was a girl of six years, who consulted

me on August 9, 1886, on account of sore throat of three days' duration. Temperature 100.3, lungs sound; breath has sweetish raw-meat odour. The tonsils were covered with a tough, loose membrane, and a glairy fluid exuded from the follicles. (A similar tonsil in a boy was well in three days.) I ordered soda, rhubarb, and creosote and grey powder. 11th—The membrane was there, but loose and no larger; throat as before; there was slight huskiness in breathing; and the laryngoscope (which, on account of the patient nature of the child, was easily used) showed the vocal cords in sub-acute inflammation; but no exudation was present. Pulse 102, temperature 98.4. Ordered iodine inhalation; R. Quin. Sulph., Dil. Sulph. Acid., Syr. Tolu, T. Camph. Co. every three hours. 13th—I visited her. On the previous night she was almost choking. When I saw her she was lying on the left side; breathing with extreme difficulty; much wheezing; croupy cough; pulse 114; temperature 100; fidgety and fretful; one or two loose white spots of old membrane remain on tonsils; otherwise throat is clear. The laryngoscope showed larynx covered with membrane. I painted over larynx with iodine, but applied poultice for the pain, the weight of which, however, embarrassed her so much that I replaced it with flannel, dry. There is stridor in laryngeal breathing, with stethoscope, even in apparent calm. Gave 1-20 grain of pilocarpine nitrate, and soon relieved the breathing; lay easy in bed. The cough is easy; can speak in muffled voice. R. Pot. Bromid. with mixture; milk alone as food, and gr. 1-20 pilocarpine to be given if breathing bad. She died at 4 a.m. on 14th, without a struggle. The mother had previously given one or two doses on account of difficult breathing. I have already given the results of my autopsy in pathology notes. I would add that after placing the membrane, which formed a cast of the respiratory track, and even the epiglottis in $2\frac{1}{2}\%$ bichromate, and $\frac{1}{2}\%$ sulphate of copper solution, it showed evidence of containing life on the 24th, and by the 30th a pretty large growth on gelatine was evident. I was six miles distant from this patient, hence I could not watch her so well. H. H., $\text{ \hat{a} t. 12\frac{1}{2}$ years}, her brother, was brought to me on August 16, 1886, almost unable to stand; he lay down in my surgery. Had rigors in the morning. There was a diphtheritic patch on the right tonsil adherent; tonsils, as in all the family, were hypertrophied. With caustic soda it became as tough as leather, and dissolved by dilute sulphuric acid. Pulse 115; omitted to note temperature. R. Quinia, Acid Hydrochloric, and Pot. Chlorate, with T. Cinchonæ Co. to flavour—for I re-

gret it is useless as a chinchona preparation, as found by using personally. 17th—Mother reports not much better; throat swollen and painful; breathing is more difficult, and through the nose; seems a little stronger, and appetite is good. 19th—Regurgitation through nose; glands large; tongue cleaning; bowels confined; appetite fails; wishes for solid food (report); urine contains trace of albumen. 20th—I visited him. Pulse 84; temperature normal; herpes on nose; speech very nasal; tonsils clear; tongue furred, with appearance of bleeding spot. 23rd—Brought to surgery—6 miles; hæmic bruits; nasal speech nearly gone; very weak; bleeding spots on tongue and nose (c. f. Zymotics, Enteric, &c.). R. Liq. Arsen. and Quin., with Calc. Hypophos. 23rd—Dysphagia, which soon disappeared. He was discharged well. H. H., æt., 4½. On December 23 presented diphtheritic patches on both tonsils, which had the chemical reactions of her brothers. She had husky voice, and the stethoscope, detected rough laryngeal breathing, p. 80. Mixture as for brother, and mint and turpentine inhalation. She has been out of sorts and off appetite since 20th, with rigors, &c. On the 24th and 26th, reports that breathing was laboured and difficult. There is trace of albumen in the urine. 29th—Throat clear; laryngeal breathing almost pure; low tones of voice, muffled. October 1—No albumen; slight spasm when angry, otherwise well. 8th—Lungs and larynx free; iodide of iron and hypophosphate of lime. The child was peevish and bad tempered; would not allow examination; was treated by me in May and June, 1885, for ophthalmia and bronchitis of old standing. The larynx gave indications on October 26 of being weak, but otherwise recovery was uninterrupted. There were other five children in the house—one at mother's breast, the other at her sister's, and all younger than the patients. The youngest suffered from eczema of the ear, with discharge, and had slight tonsillitis; the rest suffered nothing. Not to be tedious by detailing other cases of croup—for cases of diphtheria fully described can be had in numbers, as in Greenhow's book, &c.—I shall make a few general remarks. Cases of croup answering the descriptions given have been detailed to me by parents; in some cases recoveries have occurred with Ipecac. treatment; but there have been serious misgivings—some, to indicate their own powerlessness, have said, "God alone has worked this," taking credit for their cures in minor cases. How modest! Others I have seen offered tracheotomy, and ultimately recover by using ammonia, while many run on their course to death—gasping for breath, as it would be strange if anything else occurred,

seeing that the lungs are almost useless from a respiratory point of view. There is, however, the spasm of the complaint, sometimes of an hysterical nature, and the opposition to appliances on the throat. I have not seen such spasm in diphtheria, and I may be excused for hinting my belief that the membrane of diphtheria seems to have different habits—to spread in a less general way, *i.e.*, in patches. I have never had an autopsy in a case of diphtheria, and have seen but one death. A young man convalescing called at a house where his mother was nurse during the confinement of a lady. I asked him what he wanted, but I suppose he had kissed the child before I saw him. The death of her most coveted son in a few days from diphtheria and hæmorrhage from the ear caused great regret to the mother. An autopsy was not allowed. There was no other case in the house. There are, however, numerous cases described as croup, and recurring croup, too, yielding easily to simple treatment—leaving out of reckoning cases of laryngitis and laryngismus stridulus, which, as Bristowe says, are frequently mistaken for true croup. It should not be forgotten that a child suddenly awakened from sleep or suddenly waking up from a sound sleep breathes with difficulty, sometimes so badly as to cause alarm to parents. Drop a little water on a child's face and watch the effect on the laryngeal breathing. I dare say most of us could recall similar experiences; still I have been consulted regarding the former. There is no doubt a wide difference in the views of ailments taken by medical men; one fearing croup, and diphtheria will play the spray, and congratulate himself on his success. There are no doubt cases in which the mucous glands are irritable, which show the so-called croupy symptoms, and may be called croup of a slight kind, just as diseases manifest themselves with varying degrees of severity. Still these must not be confounded with laryngitis or laryngismus stridulus. Perhaps I shall be excused for giving notes of a case of laryngitis and a case of diphtheria in young children. K., æt. 14 months, was seen on January 12, 1883, at 4 p.m. Mother gave a Jennings' powder. At 8 p.m., temperature 103·8, laryngeal hoarseness (a different stethoscopic result to membranous laryngitis); slight muffled cough; no bronchial rales. R. V. Ipecac. and Antimon., mustard poultices to throat (not the objections as in croup). 13th—Temperature in rectum at noon 102·5; throat showed reddening of fauces; yellow expectoration; grey powder gr. v.; wadding and gutta percha tissue to throat, as it is red. 14th—Bowels moved; hoarse cry; cough muffled; throat clear. 15th—Temperature 102. Sweats much; follicular tonsillitis; T. Cinchon., V. Ipecac. and Ammon.

16th—Temperature 98.4. Muco-pus about mouth. 17th—Nit. Mur. and Bark. 24th—Some bronchitis. February 8, well. This occurred in a damp climate. To exemplify diphtheria, B., æt. 7 months, was seen on October 12, 1885, with membrane very adherent to tonsil, and reacting chemically like diphtheritic. There were laryngeal symptoms. Nitromuriatic and Quinine, with Chloral; Calomel every four hours, and inhaling turpentine and cajuput oil. The child was brought seven miles, so I sent him away as soon as possible. 18th—Visited. Temperature 101. Trace albumen; membrane not extended. 15th—Membrane off; tongue cleaner; breathing easy; no albumen in urine; leave out chloral. The children differed greatly in temper; the second was good and free from nervousness; allowed the throat to be examined, when a little later I detected a slight redness. Some difficulty of swallowing occurred in the diphtheritic case, but transitory in nature. Where the amount of drug dispensed is not given, the ingredients are in ordinary proportions, and administered in frequently repeated small doses. Such a course commends itself on two grounds. (1) The stomach tolerates and absorbs more easily. (2) The medicine is thus more active. Are we then, in the face of facts, to look on croup as a disease which takes place suddenly? Are my three descriptions one disease? Are the really bad cases of croup real croup? I may be excused for saying that in the disease which I have here described as croup, and which I believe to be essentially an affection of mucous glands, I have always the greatest anxiety, even after the case has gone on for some time, while in diphtheria and in laryngitis as soon as the main symptoms have gone, I keep my mind easy—there is the recovery constitution apparent. The disease is deep in the glands in croup. I cannot help quoting a remark by my old friend and clinical lecturer, Dr. Beveridge, to the effect that diphtheria, as a rule, runs its course in spite of treatment. It is this running of its course which I believe to be the true difference between croup and diphtheria—and the backward state of physiology has hitherto prevented a more intelligent treatment of diseases connected with the mucous secretion. I note from Landois and Stirling, increased secretion accompanies congested mucous membrane, division of the nerves on one side of the trachea also does cause increased secretion—membrane becomes congested. If ice is placed on the belly of an animal so as to cause it "to take a cold," the respiratory membrane first becomes pale, and afterwards there is a copious mucous secretion, the membrane becoming deeply congested. Injection of Sodium

Carbonate and Ammonium Chloride limits the secretion. Alum, Ag.NO₃, or Tannic Acid locally dry the membrane and cause shedding of epithelium. Secretion is increased by Apomorphin, Emetin, Pilocarpin, and Ipecacuanha, while it is limited by Atropin and Morphia. This is all the assistance that scientific physiology can give us. No word of inspissation even in pathology notes—no word of the effect of a bath. Surely physiologists do not reckon a mucous gland of much account. To dilate on the spasmodic breathing connected with croup would be superfluous. I have seen a case of phthisis—both lungs almost gone (one quite so)—with breathing so laboured and hissing as to make one doubtful if one's eyes deceived one on beholding, with *P. M.*, a small ulcer at the base of the epiglottis. There can, I think, be little doubt that true croup has a neurosal element, just as have the dry mouth with thick mucous secretion and such like states above mentioned. Besides, the glandular system throughout the body has wide sympathies—unknown as yet. The tonsil has its follicles. The tendency to a catarrh in these will probably affect its neighbours, the larynx and thyroid. The matter of micro-organisms is difficult to divine, but in a follicle, wounded, so to speak, there is good cultivation ground. A micro-organism requires a special soil—all do not live on mucin—and, besides, it is a foreign body, but, like all foreign bodies, as soon as nervous irritation has subsided, it will be ejected by the common scavengers and excretory channels. This now brings us to the question of treatment. For diphtheria I would say promote secretion, keep up the general health, and treat as simply as possible. Iron has been vaunted as a specific. After seeing it ejected from the stomach there is not the same inclination to give it. Why do I give quinine, chlorate of potash, and H. Cl.—forming nascent chlorine, a disinfectant? Low organisms occur in a bowel which is inactive, and to minimise irritation these must die. The acid helps to clear out the stuffs lying in the bowel. I will not say that this also assists in clearing off the membrane; it acts like good drainage, I believe, in the case of surgical wounds. A chancre, notwithstanding the hellish appliances which have been devised, will yield to cold water. The alimentary channel is more complicated. As to the albuminuria, tonsillitis, and other ailments may have it as a complication; but to enter into the sequelæ of diphtheria would be too long. The lax and flabby system (anæmic) following the disease is better to be attended to, so that there will be less chance of other ailments taking place. Remember the local subcutaneous ulcer of

the hand in connection with local treatment. Corrosive sublimate as a local application has been used with success by Koch, so has Biniodide of Mercury, and its far-extending and long-lasting action may serve to fulfil the requirements I have mentioned. I have painted it with a solution of perchloride of iron mixed with corrosive sublimate. Pilocarpine and chloral are said to be good—reduce irritation, increase secretion. Papayatin dissolves croup and diphtheria membranes in three to five days (Rosebach and Bouchut). I cannot speak of this, but the time is long. Homœopaths give bichromate of potash—a disinfectant. Of croup therapeutics, what am I to say? Patients at times recover or die, in spite of treatment, and so I do not exhibit cases of recovery as models. I have had a case do well with bromide of soda, H_2SO_4 and bark. Still, I think the blanket bath can scarcely be over-estimated. Inhalations please; spray pleases, but cools. I cannot but consider pilocarpine as a valuable, although dangerous, drug. Ipecac., &c., have their advocates. Looking back on my cases, I think it will be admitted that the irritant effect of calomel was injurious, and that a soothing regimen was indicated. Seiffart says 12% of the cases of croup and diphtheria died, tracheotomy was without effect. Voigt says 21.27% children of 47 tracheotomies recovered in Strasbourg. Dr. Crago's experience, *A. M. G.*, are better, but less numerous. Put these cases along with the fact that there was a possibility of neither croup nor diphtheria being present, and we may arrive at a just conclusion. I have known two practitioners go to perform a tracheotomy and find the child covered with measles rash. No doubt tracheotomy gives rest, and drains, but the tube also irritates. What, then, is to be done? There is prophylactic treatment of children who are liable to tonsillar affection, and tendencies to neurosal laryngeal troubles—the treating of such cases with great care, not forgetting the risks which may occur. When the case is decided—*i.e.*, when a single vomit or simple treatment fails to bring back healthy secretion, the indications appear to be to lessen irritation and promote secretion everywhere in the best ways possible, so as to bring back a state of health and then to support strength. The intestinal canal will require the same attention as in diphtheria; but more caution is required, for the canal is probably irritable. I have elsewhere recommended the topical application of Drumine, and from its effect on the thirst, &c., arising in hot weather, I think it promises well. There can be little doubt that time is required to bring about a healthy state of matters. I made experiments with a drug which appeared to act on mucous secretion, but

my experiments are not complete. A good future is promised for the glucoside. I cannot help ending this paper with the two statements—first, that there is a great and widespread dread of infectious diseases among the profession and laity (although I have never had scarlatina or smallpox, I never feared when my health was good to handle freely both kinds of patients in well-ventilated houses); second, that there still remains, rooted in the medical mind, as well as in the laity, the belief that diseases must be driven out by hook or crook, without at the same time considering the two factors in the case. Such is very much true regarding diphtheritic local applications. To illustrate: "Constrained not only to endure diseases, but, what's worse, the cure."

143 Collins Street East, Melbourne.

REPORTS OF SOCIETIES.

QUEENSLAND MEDICAL SOCIETY.

GENERAL MEETING, held at School of Arts, Brisbane, on Tuesday, August 9, at 8.30 p.m. Present: Drs. Bancroft, Mullen, Hill, Geoghegan, E. H. Byrne, Gibson, O'Doherty, W. S. Byrne, Shout, Lyons, Rendle, Taylor, Little, and Love.

Dr. Lucas, of Melbourne, was present as a visitor.

The minutes of the last meeting were read and confirmed.

Dr. W. S. BYRNE proposed and Dr. LOVE seconded for membership—

J. S. CLOWES, M.R.C.S., Albion.

ANNUAL DINNER.—Dr. LOVE proposed and Dr. HARE seconded, that an Annual Dinner should be held some time in October. Carried.

The selection of a sub-committee was referred to the Council.

The University question was next dealt with. After discussion of the subject by Drs. RENDLE, GIBSON, W. S. BYRNE, LITTLE, and LOVE, Dr. TAYLOR explained that technical education was the main object of starting a University.

Dr. RENDLE said that if he had known that, he would not have proposed the resolution standing in his name. What he objected to was a University with degree-granting powers; he therefore withdrew his motion.

The PRESIDENT remarked, that with the modifications stated by Dr. Taylor, such an institution would be acceptable to all, but no such provisions were contained in the circular sent him by the Chief Justice.

Dr. W. S. BYRNE moved, and Dr. LITTLE seconded, that "The Society is cordially in favour of the immediate establishment of a College of Science and Art, which would form the nucleus of a future University, but this Society is of opinion that the establishment of a University capable of granting degrees in Medicine, Law, and Divinity, is premature." Carried unanimously.

The foregoing resolution was ordered to be drafted, and prepared for the signatures of all the members of the Society, and then to be forwarded to the Chief Justice, to be handed to Parliament.

Dr. TAYLOR then read his paper on the conditions favourable to the development of diphtheria.

The paper being lengthy, and accompanied by numerous extracts, the discussion of the subject was postponed till next meeting, owing to the lateness of the hour.

The President drew the attention of members to the fact that the hour of meeting was 8.30, and urged punctuality, for the sake of country members in particular.

GENERAL MEETING, held in the School of Arts, Brisbane, September 13, at 9 p.m. Members present, Drs. Taylor, W. S. Byrne, E. H. Byrne, Hill, Owens, Gibson, Shout, and Love.

Dr. TAYLOR was moved to the chair in the absence of the President.

The minutes of last meeting were read and confirmed.

Dr. LOVE showed for Dr. HARE a specimen of a Fallopian gestation, which had ruptured into the abdomen, causing death in a quarter of an hour.

The SECRETARY read a letter from Mr. EGLINTON, School of Arts, offering for sale to the Society an old copy of anatomical plates, which had been the property of a surgeon, and had been offered to him by the late owner's widow. After discussion, it was resolved to purchase them for 30s., the money to come out of the library funds.

Dr. OWENS showed a multilocular cyst of the iris.

The SECRETARY read a letter from Mr. BRUCK respecting the publication of proceedings and the subscription to the *Australasian Medical Gazette*. The proposal to increase the subscription to £2 2s., that sum to include subscription to the *Australasian Medical Gazette* was favourably received by those present.

Dr. TAYLOR supported the printing of the proceedings separately, as a first step towards the establishment of a local medical journal.

The merits of the question were discussed.

Dr. W. S. BYRNE gave notice that he would move the following motion at the next meeting:—

"That the subscription to the Society be raised to £2 2s. per annum, that sum to entitle the subscriber to a copy of the *Australasian Medical Gazette* monthly.

A discussion then followed on Dr. Taylor's paper on the causation and origin of diphtheria, Drs. GIBSON, OWENS, and TAYLOR joining in the discussion.

GENERAL MEETING, held in the School of Arts on October 11. Present: Drs. Little (in the chair), Rendle, Tilston, McNeely, Neill, Hill, Clowes (visitor), Jackson, W. S. Byrne, E. H. Byrne, Taylor, Gibson, and Love.

The minutes of last meeting were read and confirmed, Dr. LOVE proposed, and Dr. W. S. BYRNE seconded. T. N. FLOOD, M.B., C.M., Beenleigh, as candidate for membership.

Dr. CLOWES, of Albion, was unanimously elected as a member of the Society.

Dr. BYRNE then brought his motion before the Society—"That the annual subscription be raised to £2 2s., that sum to entitle each member to a copy of the *Australasian Medical Gazette* monthly."

The SECRETARY moved, and Dr. NEILL seconded: "That the subscription remain as at present, but that the members be urged to support the *Australasian Medical Gazette* as the journal of the Society."

After some discussion, in which very complimentary reference was made by several members of the Society to the *Australasian Medical Gazette*, the amendment was declared carried on a division.

The petition to Parliament regarding the University question was signed by the members present.

The SECRETARY announced that the sub-committee appointed by the Council to arrange for the annual dinner had agreed upon Thursday, October 27, as the most convenient date, the meeting to be held in the rooms of the Johnsonian Club.

The names of members then intending to be present were enrolled by the Secretary.

Dr. JACKSON showed a large renal calculus removed *post-mortem*, which had not been suspected during life; also a large bloody tumour attached to the popliteal surface of the femur. The diagnosis lay between angioma and aneurism (false).

Dr. LOVE showed a number of large gall stones, removed *post-mortem* from a woman who had been urged by Dr. TILSTON to go into hospital for cholecystotomy, but had refused.

A number of new instruments and pharmaceutical preparations were exhibited by the kindness of Messrs. Elliott Bros., and a number of circulars sent from Messrs. Burroughs, Wellcome and Co.'s Melbourne branch were laid upon the table.

GENERAL MEETING, held at the School of Arts, November 13. Dr. Little took the chair in the absence of the President, who was still suffering from a recent illness. Present: Drs. Little, Rendle, Taylor, Thomson, Ryan, Hare, Owens, Tilston, W. S. Byrne, E. H. Byrne, Shout, and Love.

The minutes of last meeting were read and confirmed.

Dr. THOMAS N. FLOOD, of Beenleigh, was elected a member of the Society.

The SECRETARY read for Dr. HOGG a paper on the use of the naso-oesophageal tube in forcible feeding.

Dr. RYAN, of Gympie, then read his paper on "Abdominal Section," introducing the notes of five successful cases (four ovariectomies and one gastrectomy) on which he had operated.

Dr. OWENS gave a full and detailed account of the mode in which Mr. LAWSON TAIT operated in his abdominal section.

A vote of thanks was passed to Dr. RYAN for his paper, and to Dr. OWENS for his very interesting description.

The SECRETARY apologised to the meeting for the mistake in the date, the second Tuesday having fallen on the 8th.

The SECRETARY acknowledged, on behalf of the Librarian, with thanks, the receipt of twenty copies of the *Australian Medical Journal*.

A number of tinctures, infusions, &c., of local manufacture, were shown by the kindness of Messrs. Elliott Bros.

NEW SOUTH WALES BRANCH B.M.A.

THE 68th General Meeting of the Branch was held in the Royal Society's Room, Sydney, on Friday, 4th November, 1887. Present—The Hon. Dr. Creed, M.L.C., President (in the chair); Drs. Chambers, Chisholm, Sydney Jones, Pockley, Knaggs, Wright, E. Fairfax Ross, Steel, Worrall, Hankins, McCormick, McDonagh, Bowker, West, and Crago.

Visitor—Dr. A. E. Barcroft.

The minutes of the previous meeting were read and confirmed.

MR. G. T. HANKINS, exhibited a patient on whom he had performed ligature of the sub-clavian artery for axillary aneurism a month previously. Prior to the operation electrolysis had been used, but with insufficient success. A current of 140 milliampères was passed through the aneurism for 30 minutes, by means of 4 insulated needles connected with the positive pole. The ligature in this case was of carbolised catgut, and the wound healed by first intention. Pulsation could first be detected in the radial 26 hours after the operation.

DR. SYDNEY JONES said MR. HANKINS was to be congratulated on the success of the operation. He (Dr. Jones) would like to see a new series of statistics published on the mortality of the patients on whom the larger operations had been performed, and he felt certain that if such statistics were published the result would be eminently satisfactory. The statistics upon which all calculations are now based were collected before antiseptics were used. If the results of the operations of the last eight or ten years were collected, a great difference would no doubt be found.

DR. WORRALL, enquired if there were any history of syphilis, and was answered in the negative.

DR. ROSS had seen a similar aneurism treated in London, by incision of the sac and ligature of the two ends of the artery.

MR. HANKINS also showed a patient from whom he had removed the whole of the penis and testicles six weeks before for epithelioma. After an incision along the raphe of the scrotum the urethra and corpus spongiosum were dissected from the corpora cavernosa and brought out through an opening in the perineum, an inch in front of the anus. The upper surface of the urethra being slit up for the distance of half an inch and attached to the skin by eight horsehair sutures. The whole of the penis was then removed by dissecting the crura from the rami of the pubes and ischium, after the manner of Professor Thiersch, of Leipsic. The testicles, which were healthy, were also removed with the redundant skin of the scrotum as recommended by Mr. Wheelhouse. The wound healed by first intention and shows a linear cicatrix in the middle line at the bottom of which is the orifice of the urethra. The patient uses a tin spout so that he can micturate without sitting down, as suggested by Sir Wm. MacCormac. The genital organs now closely resemble those of a female. The inguinal glands, which were much enlarged, have considerably diminished in size since the removal of the source of irritation.

DR. SYDNEY JONES commented upon the superiority of Thiersch's operation over the old amputation by a clean sweep of the knife, thus preventing the excoriation caused by the dribbling of urine over the scrotum. He also bore testimony as to frequent subsidence of the inguinal induration after the operation.

DR. SYDNEY JONES also said that Mr. Jackson, of Wolverhampton, had a case of this description in which the glands were very much enlarged at the time of the operation; but he saw the patient 12 months after,

when the enlargement had entirely disappeared. The result of this operation had been highly satisfactory.

DR. CRAGO read some notes on a case of Diabetic Coma.

MR. HANKINS asked DR. CRAGO what appearances did he expect if he had been able to have had a *post mortem* examination.

DR. CRAGO replied that the reason he had wished for a *post mortem* was to verify the diagnosis.

DR. KNAGGS said he had seen this case in consultation with DR. CRAGO, and there were two things prominently brought before them, namely,—pregnancy and narcotic poisoning, and it was to make sure of the real cause of death that we wanted to have a *post mortem*.

The President then announced that the next business on the paper was the revision of the by-laws.

DR. JONES proposed and DR. CRAGO seconded that the consideration of the by-laws be postponed until the next meeting night and that it be the first business of the evening. Carried.

DR. LEACOCK, of Camden, was elected a member of the Association.

MEDICAL SECTION OF THE ROYAL SOCIETY OF NEW SOUTH WALES.

MONTHLY MEETING.—Held in the Society's Rooms, Sydney, on November 18, the President (Dr. Sydney Jones) in the chair.

PRESENT—Drs. Goode, Garrett, Crago, Walter Blaxland (visitor), Herbert Blaxland, Worrall, Chisholm, Maudsley (visitor), Ross, MacCormick, Twynam, Hankins, Roth, Lyden, Carruthers, Foreman, Eichler, Brady, Skirving, Martin, Schwarzbach, Bowker, O'Reilly, Marshall, Faithfull, Jenkins, and Shewen.

DR. CHISHOLM showed a patient with a large intra-thoracic tumour, right side, probably hydatid, which case excited great interest.

DR. WORRALL read a paper on a "Remarkable Case of Faecal Accumulation"—abdominal section was performed, and the patient made an excellent recovery. Drs. ROSS, FOREMAN, TWYNAM, HANKINS, SYDNEY JONES and HERBERT BLAXLAND joined in discussion.

DR. JENKINS exhibited a large fibroid polypus removed from the posterior lip of cervix uteri of a woman aged 51. This patient had been under the treatment of an unqualified practitioner for three years, who had, under the impression that the polypus was a prolapsed uterus, been endeavouring to keep it up with all kinds of pessaries. The polypus was fibroid in nature, weighed three pounds, and was removed by scissors, a ligature having been placed round the broad base. The patient made a rapid recovery. Drs. WORRALL, FOREMAN, and SYDNEY JONES, joined in the discussion.

DR. CHISHOLM exhibited a specimen of frontal lobe of brain with a large abscess.

DR. ROSS exhibited specimen of kidneys of patient, who died with symptoms of retention of urine. The ureter of the right kidney was obstructed by a calculus, the left kidney was extremely small and showed signs of grave cirrhotic change, and there was a phosphatic mass in the site of the supra-renal capsule. An accurate diagnosis had been made during life. Mr. HANKINS made a few remarks.

DR. SCHWARZBACH read an interesting paper on the use of corrosive sublimate in conjunctival and corneal affections, and especially in granular ophthalmia. Drs. FAITHFULL, TWYNAM, JONES and BOWKER joined in the discussion.

THE NEXT INTERCOLONIAL MEDICAL CONGRESS OF AUSTRALASIA.

THE Provisional Committee of the next Intercolonial Medical Congress held its first meeting on the 6th inst., in the hall of the Medical Society of Victoria. The president-elect, Mr. T. N. Fitzgerald, occupied the chair, and there was a large attendance of members, including representatives of the Medical Society, the Victorian branch of the British Medical Association, the Ballarat District Medical Society, and the Bendigo Medical Society.

PRESIDENT'S ADDRESS.

The PRESIDENT-ELECT, in opening the proceedings, said that a debt of gratitude was owing to the members of the profession in South Australia for their courage and scientific spirit in initiating a series of Intercolonial Medical Congresses, and also for the hearty hospitality which was displayed towards visitors during the progress of the first session. At the close of that session a special meeting was held to elect the President for the second session, and to determine the place and time at which it should be held. The meeting did him the honour of electing him President. Professor Allen, after consultation with all the Victorian representatives who were present, kindly undertook the responsible duty of inviting the congress to hold its next session in Melbourne, and this suggestion was unanimously agreed to. Debate then arose concerning the date, the general feeling being that the meetings should not be too frequent, for otherwise they would lose in dignity and weight. Ultimately it was resolved that the second session should be held in 1890, or at such earlier time as the medical societies of Victoria might determine. Professor Allen undertook to lay the matter before these societies, and would now read an abstract of his correspondence.

PROFESSOR ALLEN'S REPORT.

Professor ALLEN reported that, on returning from Adelaide, he submitted the following proposal to the four medical associations of Victoria:—That the medical societies of Victoria empower a provisional committee to fix the date of the next session of the Intercolonial Medical Congress of Australasia and to make all needful arrangements for such session until a general meeting of enrolled members can be held, at which a progress report shall be submitted, such provisional committee to consist of the president-elect, six representatives chosen by the Medical Society of Victoria, six by the Victorian branch of the British Medical Association, three by the Ballarat District Medical Society, and three by the Bendigo Medical Society, the committee having power to add to its number. The four associations approved this proposal, and representatives were appointed as follow:—By the Medical Society of Victoria—Professor Allen, Dr. J. Jackson, Mr. E. M. James, Dr. Jamieson, Dr. Neild, and Dr. J. Williams; by the Victorian branch of the British Medical Association—Dr. Cutts, Dr. Graham, Dr. Henry, Dr. Rowan, Mr. Rudall, and Dr. Springthorpe; by the Ballarat District Medical Society—Mr. Radcliffe, Mr. Tremearne, and Mr. Whitcombe; by the Bendigo Medical Society—Dr. Hinchcliff, Mr. MacGillivray, and Mr. Penfold.

ELECTION OF OFFICERS.

On the motion of Mr. E. M. James, seconded by Mr. MacGillivray, Professor Allen was unanimously appointed secretary. Professor Allen accepted the position, but intimated that, as the official duties would

be onerous, he would, at an early meeting, request that associate secretaries be appointed.

On the motion of Professor Allen, seconded by Mr. Penfold, Dr. Graham was unanimously elected treasurer.

POWER TO ADD TO NUMBER OF COMMITTEE.

The PRESIDENT-ELECT said that the next business was to consider the power of the committee to add to its number. This introduced a question which he deemed of fundamental importance as regards the success of the congress. It was, unfortunately, a fact that the recent congress in America fell short of the success which it should have achieved in consequence of internal dissensions in the profession. Probably this was due to a want of care in the conduct of business at the very initiation of the congress, sufficient precautions not being taken to make the managing committee truly and fully representative of the profession. Even in this colony it might be said that the four societies whose delegates were now assembled did not fully and completely represent the profession. There were several eminent members of the profession holding high official position whose absence from the committee must be an element of weakness; and he was inclined to think that it would be wise for the committee to exercise somewhat freely, though with due care, its power to add to its number.

Discussion followed, in which general concurrence was expressed with the views of the President. On the motion of Dr. Springthorpe, seconded by Dr. Hinchcliff, it was resolved to invite the following gentlemen to join the committee:—The Chancellor of the University, the President of the Medical Board of Victoria, the Government Medical Officer, the Inspector-General of Asylums, and the Government Botanist. It was further resolved, on the motion of Mr. MacGillivray, seconded by Dr. Jamieson, that at the next meeting proposals for the appointment of additional members be received, so as to secure a full representation of the profession.

DATE OF NEXT SESSION.

On the motion of Dr. J. Williams, seconded by Dr. Hinchcliff, it was unanimously resolved that the second session of the congress be held in 1890. The exact date was left for settlement at a subsequent meeting.

TERMS OF MEMBERSHIP.

On the motion of Dr. Jamieson, seconded by Mr. E. M. James, it was resolved that payment of one guinea constitute membership, and entitle every member to a copy of the published transactions of the congress. It was also resolved, on the motion of Dr. Hinchcliff, that a guarantee fund be established to provide for any possible liabilities which might remain at the conclusion of the congress, the liability of each guarantor being limited to £5.

APPOINTMENT OF SUB-COMMITTEE.

The President, the Secretary, Dr. Cutts, Dr. Neild, and Dr. Williams were appointed a sub-committee to draft a circular addressed to the members of the profession throughout Australasia, such circular to be submitted for approval at the next meeting of the provisional committee. The sub-committee was requested, also, to draft rules for the guidance of the committee in matters of procedure.

DATE AND PLACE OF NEXT MEETING.

It was resolved that the committee meet again on Tuesday, 10th January. Professor Allen, on behalf of the committee of the Medical Society, offered the use of the hall of the society for all meetings of the provisional committee. The offer was accepted with thanks.

The committee then rose.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number. All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, DECEMBER 15, 1887.

EDITORIALS.

REGISTRATION OF DEATHS IN SYDNEY.

THE Registrar-General apparently has recently woke up to the fact that the department under his control has hitherto not done all it might have accomplished in the protection of life against crime, even with the defective Registration Act at present in force in New South Wales. We hear the undertakers are now required to send in reports of burials conducted by them within a few days of their taking place, instead of the matter being left to their own sweet will as heretofore, and an occasional prosecution takes place if they neglect to do so. As a result of this new born activity, a woman named Anne Wylde was summoned at the Water Police Court on November 22. The information was laid by Edward Grant Ward, Registrar-General of the colony, who set forth that he had just cause to suspect and believe, and verily did suspect and believe, that Ann Wylde, on the 19th day of May, in the year 1887, at Sydney, did wilfully make a false statement respecting the birth of a certain child (that is to say)—“I hear beg certify that I delivered Mrs. Linesey of a dead-born mail child, Thursday, 19th; Mrs. WYLDE, ANN WYLDE,”—for the purpose of having the said statement inserted in a register of deaths kept at the cemetery at Rookwood, the birth of the said child being in particular required by law to be registered, whereas, in truth and in fact, the said child was not born dead. After hearing evidence his Worship committed the accused to take her trial at the next Court of Quarter Sessions. The woman was admitted to bail in the sum of £40.

This certificate is not at all unique, and in its originality of spelling, &c., is not to be compared with the twenty which were reproduced as an appendix to the report of the Select Committee of

the Legislative Council of New South Wales on the Registration of Births, Deaths and Marriages, which was appointed, in 1886, on the motion of the editor of the *A.M.G.* The Registrar-General, according to the evidence given by him before this committee, and also before the one which has recently reported as to the practice of Medicine and Surgery, has some highly original ideas regarding certificates as to the cause of death. He said that “we take them from anybody at present.” A Parliamentary return shows that he was speaking but the bare truth when he said this, for it shows that he or his subordinates have accepted certificates from men, who by their examination before the Select Committee acknowledged themselves to have had no teachers or training, and besides from a man without qualifications, who is now serving a term of fifteen years’ penal servitude for criminal malpractice.

THE PRACTICE OF MEDICINE AND SURGERY IN NEW SOUTH WALES.

IN this issue we reprint the report of the Select Committee on the Practice of Medicine and Surgery in New South Wales, which was brought up by the chairman on Wednesday, December 7, and ordered to be printed, together with evidence taken during the present and last session of Parliament. The report is thoroughly supported by the evidence, and it is to be hoped that legislative action for the remedy of the great evils which have been shown to exist will quickly follow. It is to be observed that the report specially urges the introduction of a measure by the Government, and points out that such a measure as is required could not be effectively brought forward by a private member. This was also the view expressed in a letter sent to the Premier in September last, signed by the Lieutenant-Governor Sir Alfred Stephen, G.C.M.G., C.B., the Chief Justice Sir Frederick Darley, His Eminence Cardinal Moran, Archbishop of Sydney, the Primate, and some eight other gentlemen filling representative positions in New South Wales.

It is to be hoped that public opinion has been sufficiently aroused and that the Government supported by it will act promptly and effectively.

The evidence taken has been of so startling a character that it has aroused attention, not only in the colony concerned, but in all Australasia, and throughout the civilised world, demands for copies of the evidence having been received from England, the continent of Europe, America, and India.

THE AUSTRALASIAN MEDICAL GAZETTE.

THE number of our subscribers having now exceeded the first quarter of the second thousand, we trust our readers will permit us to furnish them with a short retrospect of our doings in the past. The *Australasian Medical Gazette*, since it was started, more than six years ago, has enjoyed a steadily and, of late, even rapidly increasing circulation. Nearly one half of all the medical practitioners throughout the colonies, from the Northern Territory to Tasmania, and from Western Australia to New Zealand and Fiji, are subscribers to our journal, as well as many other gentlemen in other parts of the world. Numerous valuable original papers and society discussions have been laid before our readers. During the past twelve months alone we have published not less than one hundred and five original articles, contributed by the *élite* of the profession in Australasia; 48 of the papers contributed came from New South Wales; 24 from South Australia; 12 from New Zealand; 11 from Victoria; 9 from Queensland; and one each from Western Australia, Tasmania, Northern Territory, New Guinea, U. S. America, and England, which abundant support in contributions we deem the best proof that the *Gazette* is appreciated by members of the profession throughout these colonies. In our editorial columns we have always expressed, without fear or favour, our views on current topics of interest to medical men; we have done all in our power to uphold the dignity of the profession, and have endeavoured to claim for its members the respect and consideration which are due to them by the general public; all items of intercolonial medical news of permanent interest have been given in brief memoranda; our readers have been kept *au fait* with what is going on in the different hospitals and universities; the mortality and meteorological observations throughout the colonies have been recorded, in short, we have endeavoured to give the *Gazette* a strictly intercolonial character, and to make it a medical journal such as the profession in these colonies needs, and which it can be proud of, and this policy, to which the *Gazette* owes its unprecedented success, and which has made it a welcome and almost indispensable visitor to its readers, will be adhered to in future, so we think we may fairly hope that the great interest hitherto shown to the *A. M. G.* by the profession in all the colonies, may still continue to increase.

LETTERS TO THE EDITOR.

PILOCARPINE IN THE TREATMENT OF PUEPERAL CONVULSIONS.

(To the Editor *A. M. Gazette*).

DEAR SIR,—In the *Australasian Medical Gazette*, for September, Dr. Finnis, of Adelaide, relates a case of successful treatment by the injections of pilocarpine in puerperal convulsions. On reading his case it called to my mind a similar one which occurred in my own practice last April, and which I will briefly relate. We isolated practitioners, to whom an attendance at a branch meeting of the B. M. A. is a rare event, should be very thankful for any hints, &c., conveyed to us through the pages of your journal; but we should not absorb everything without giving back something in return.

At midnight April 1st, I was called to see X.Y.Z., a healthy young girl, aged 19. Her mistress informed me that she had been complaining of intense headache during the afternoon of the previous day, and not feeling well she had gone to bed. She had never complained before of any illness, having always been actively engaged in domestic work. I found her in an unconscious state, tossing about on the bed; both pupils fully dilated, with no reaction to light; pulse, 88; temperature, 99°, and no response to questions, though shouted in her ear. A stethoscopic examination revealed nothing abnormal with either the breast or lungs. Somewhat nonplussed at this, I made a vaginal examination, when a flood of light was thrown upon the subject, by my finding the patient in the second stage of labour. The vagina was fully dilated: the os, about the size of a two-shilling piece, with a foetal head presenting; hitherto there had been no convulsions, but after the rupture of the membranes, she suddenly became rigid, with clenched hands, closed jaws, &c.; spasm lasted about two minutes, and was quickly followed by several more. I now saw that delivery must be quickly terminated, and commenced a digital dilation of the os, as Barnes' elastic dilators were not at hand; within three-quarters of an hour I was able to introduce three fingers, and turned the infant, which was living, but died within 36 hours after. Until the birth of the infant she must have had 10 or 12 tonic spasms, each increasing in intensity. Remaining until five o'clock with her, and no further convulsions having appeared since delivery, though she was still unconscious, I concluded that she was passed the storm; but on seeing her at 8 a.m. next morning I was disappointed to learn that she had had four convulsions within the last two hours. She was still in the same state; temperature normal, pulse 88. Having a case of acute Bright's disease under treatment, in which daily injections of pilocarpine were given, I thought that a similar treatment would prove useful, and at once injected $\frac{1}{2}$ grain of the nitrate; in three minutes the usual effects were visible. At 2 p.m. the nurse informed me that she had become semi-conscious; had spoken some words; had taken a cup of gruel; and had no more convulsions. As she was in heavy slumber and very difficult to arouse, and as I was fearing a return of the convulsions, I ventured on giving another injection of gr. $\frac{1}{2}$ pilocarpine. When seen again at 8 p.m. she was conscious; recognised me and her mistress; had taken food freely; complains of no pain; the pupils are normal; but she has passed no urine for 24 hours.

April 2.—Quite sensible; has had no return of the convulsions; urine drawn off per catheter, tested for albumen, but not a trace, only ammoniacal.

April 5.—Had several rigors last night; temperature, 104°; pulse, 126; complaining of pain over the left ovary, and over the epigastrium; milk showing in the breasts. Fearing peritonitis or a return of the convulsions, I gave her *sod. salicylate gr. v. and Tinct. Jaborandi m. xx.*, every three hours.

April 6.—Temperature, 101°; pulse, 100; slept well during the night; no increase of milk; to continue the mixture for another 24 hours.

April 7.—Pulse, 90; temperature, normal; from this date she made an excellent recovery.

Now, I am convinced that the injection of pilocarpine prevented the return of the convulsions. Had they continued, what treatment is usually followed up? The inhalation of chloroform; blood-letting; or the rectal injection of large doses of bromides and chloral, have each and all been used, no doubt, successfully in a great number of cases, but the pilocarpine injection acts so quickly and is so easily effected that it should be given at first in these cases. It is to be noted that no albumen was found in the urine; the cause of puerperal convulsions has got to be discovered; albuminuria is not always present, neither will emptying the uterus of its contents dispel the eclampsia, as we find both pre and post partum varieties. But there is one thing to note especially; if we find a pregnant or parturient woman with intense headache or epigastric pain rendering her semi-conscious, with vomiting—look out for convulsions.

THOS. BAIN WHITTON, M.D., &c.

Beefton, (Nelson), New Zealand,
November 2, 1887.

MEDICAL ETIQUETTE.

(To the Editor Australasian Medical Gazette.)

DEAR SIR,—It is with much regret that I feel compelled to answer a letter emanating from Dr. Finlay, which appears in your issue of October, charging me with unprofessional conduct. As my version is somewhat different from Dr. Finlay's I give it, and leave my professional brethren to form their own conclusion.—In the first place I was sent for by the patient's friends to meet Dr. Finlay in consultation. I found the patient suffering from an enlarged and inflamed scrotum, complaining of headache, pulse 110, very restless. The scrotum was as large as an adult's head, scarlet, and tense, and though he said that he did not feel much pain in it, he shrank from the gentlest touch; he complained of a dragging pain in the back and the thighs which were flexed on the abdomen. I was informed that he had been tapped for hydrocele, by a well-known surgeon in Sydney; that the scrotum had within 24 hours attained its previous size; that it was again punctured and only a little bloody serum had escaped, without causing any diminution in its bulk. Now Dr. Finlay's diagnosis of this was cerebro-spinal fever, or as he said, cerebro-spinal meningitis. He informed me that in his opinion the inflamed organ had nothing to do with the patient's ill health. He had given a grave prognosis of the case which I thought justified by the patient's condition. Dr. Finlay asked me whether I had any cases of cerebro-spinal fever. I said, no. He then informed me that he had six or seven cases and invited me to visit them in his company, this opportunity I did not avail myself of, as the case we were then observing, and about which we had such a decided difference of opinion, did not lead me to expect much valuable information from Dr. Finlay's offer. I may here state that no other medical practitioner in

Bathurst was attending a case of cerebro-spinal meningitis. My diagnosis was that the patient was suffering from hæmatocele, with acute inflammation of scrotum and probably of the testicle, and that the whole of the symptoms arose from the local mischief. I suggested a third opinion, to which Dr. Finlay did not give any answer. I then left. During the afternoon I was waited on by Mr. B., who wished me to go at once and see the patient, a friend of his. Mr. B. informed me that Dr. Finlay would not meet a third medical man, and would have nothing more to do with the case. I expressed a strong disinclination to take up the case under the circumstances, but as the symptoms were urgent, and it was evident that the man should not die unrelieved, even out of fear of infringing professional etiquette, I consented to act in concert with another practitioner, leaving the selection to Mr. B. He suggested Dr. Bassett, and I visited the patient with that gentleman. Dr. Bassett concurred with me in the necessity for immediate action, *i.e.*—opening the scrotum, relieving tension and turning out any effused blood; this was done, as we understood that Dr. Finlay had retired from the case. Up to this there had not been one word of Dr. Barber. In the evening I visited the patient and found him somewhat improved. I was then, for the first time, informed by the wife of the patient that Dr. Finlay had called and suggested that his friend Dr. Barber should be called in. Dr. Barber, I believe, now resides at Mudgee, but at that time I was given to understand was in Sydney. I expressed surprise that Dr. Finlay should have suggested this after he had retired from the case, and drew their attention to the fact of his saying nothing of his friend at the time of our consultation in the morning. I was then informed that Dr. Finlay was in the next room. I was so indignant that I went into the room and expressed myself strongly at the behaviour of Dr. Finlay, who allowed himself to be found in the house after the operation, suggesting a consultation. I asked him why he did not suggest this gentleman to me in the morning.

The patient recovered his health as the inflammation subsided. The condition of the testicle gave me some anxiety, and I feared it might be necessary to remove it. I ask any medical practitioner whether he would not feel indignant at finding (after an operation when the patient was admittedly in a dangerous state) the former medical attendant in the house informing the patient that he would probably not live till morning, and suggesting, for the first time, that a friend of his from a distant town should be called in, a suggestion only revealed to me by the patient.—I am, yours faithfully,

WALTER W. SPENCER, M.R.C.S.

Bathurst, Nov. 26, 1887.

TYPHOID FEVER VERSUS MILK.

(To the Editor Australasian Medical Gazette.)

SIR,—Consumers of dairy produce coming from the Illawarra district will be gratified to find that since writing the letter on "Typhoid Fever versus Milk," two of the suggestions thrown out by me for insuring a more pure supply of dairy produce have been adopted. At one factory arrangements have been made for the periodical cleansing of the piggery, and at another a more radical change has been instituted in the entire removal of the pigs from the neighbourhood of the factory.

The proprietor of the *Illawarra Mercury*, the leading paper and the one having the largest circulation in the Illawarra district, admits that my remarks "though

seemingly severe, are not in the least exaggerated' and goes on to say "that to have a piggery even within 'smelling distance' of a dairy factory is highly objectionable, for sanitary reasons more especially, and that this must be plainly apparent to all." That nothing is more susceptible of becoming impregnated with foul odours and disease germs than milk and butter can be easily proved by any one who may care to carry out the following simple experiment. Place a shallow dish of newly milked milk in a byre, beside the cows, on the floor, and allow it to remain on a close warm day for a short time in free contact with the foul air close to the sewage, and the result will shortly be that the milk will become so contaminated that it will be undrinkable. To expose it or butter, under similar circumstances, in a piggery, the same result will be attained in a much shorter time.

A bucolic critic, probably a shareholder in some butter-factory, or in a company for the export of choice butter—only the best being sent to the London market—doubtless fearing a reduction in the chimerical twenty-five per cent. dividend, scouts the views of scientists in general, and of myself in particular, as to the initiation of disease from germs. This person does not believe that the use of contaminated milk and butter can be followed by typhoid fever. He even goes so far as to say that my views, as expressed, will not deter him from "eating factory butter, or drinking factory milk, if the pigs sleep in the churn." He, however, damages his cause and shows the public that my remarks are quite within the truth, when he further says, what is scarcely credible, namely, that every dairy and farm-house has not only a pig-stye, but pigs lying at the door and often inside the house and dairy.

Surely to have such foul animals as pigs lying in such close proximity to milk as to be inside the dairy, shows a great and crying necessity for the extension of the Dairies Supervision Act to the Illawarra district.

The Melbourne correspondent to the *Sydney Morning Herald* telegraphed on Sunday last, the 4th inst., "The annual epidemic of typhoid fever appears to be setting in. Eight cases were reported to the Central Board of Health on Saturday, by the Albert Hospital authorities. During the week five other cases of typhoid and six cases of diphtheria were reported to the Board."

There were ten deaths from typhoid fever in Sydney and suburbs in October last, and only five in Melbourne and suburbs during the same month.

As I have shown, defective drainage and an impure water supply are leading factors in the spread of typhoid in Melbourne, but such is not the case, to the same extent, in Sydney, and if pigs are allowed to lie at the door and inside the houses and dairies in the Illawarra district, then the presence of typhoid fever with its excessive mortality, 7.3 per 10,000, is easily accounted for. Surely my critic will have some member of his household attacked by typhoid if he is contented to live in the midst of such insanitary surroundings. This reveals a disgraceful state of affairs, but should small-pox once get a footing in the Illawarra district, where few children are vaccinated, though their parents have long since been offered the protective advantages of vaccination by pure calf lymph by myself, the mortality will speedily approach, with its foreseen horrors, that which the *Spectator* declares will result in the adoption of the method recommended for the destruction of rabbits by the eminent French scientist, M. Pasteur.—Yours faithfully,

JOHN S. WILSON, M.R.C.S. Eng., &c., &c.

"Brighton Villa," Kiama, December 6, 1887.

FINAL REPORT OF THE SELECT COMMITTEE OF THE LEGISLATIVE COUNCIL ON THE PRACTICE OF MEDICINE AND SURGERY IN NEW SOUTH WALES.

We find that, practically, no law exists for the regulation of the practice of medicine and surgery in this colony, and that, as a consequence, members of the public are liable to an amount of fraud and imposition which is absolutely appalling from its extent and from the unscrupulous boldness of the many ignorant pretenders who, without having either gone through any proper course of study or passed any examination, give themselves out as qualified medical practitioners, making use of titles and designations which lead members of the public to suppose that they have gone through the course of study required by the various universities and other examining bodies from students of medicine prior to admission for examination, and that they have successfully undergone such tests. Evidence has been given which shows how difficult it is for people requiring the services of medical practitioners to ascertain who have been properly educated and are in possession of satisfactory diplomas and who are mere ignorant pretenders; also, that the police have called as expert witnesses (being under the belief that they were properly qualified medical practitioners) men who had no title to such distinction, one of whom admitted that though he had given medical evidence in a criminal case at the Water Police Court, and had been ordered by the acting-coroner for Sydney, Mr. Pinhey, J.P., to make a *post-mortem* examination of a body and to give evidence on it at an inquest, he never in his life had had any medical training. The testimony of Messrs. Archibald, Belbridge and Plummer, as to the very numerous inquiries which are made through the press by people desiring to consult a medical practitioner, as to who is properly qualified and who is not, very forcibly shows how great and general this difficulty is. We believe that the practice of calling unqualified men as expert medical witnesses at inquests and in criminal cases is fraught with danger to the public well-being and calculated to seriously endanger the reputation and perhaps the liberty of individuals. It was shown to the committee that as the law exists in relation to medical witnesses the properly qualified medical man is placed in a positively disadvantageous position by the fact of his registration as a medical practitioner when compared with the man who is practising medicine without education or diploma. We think that the power of the Medical Board as at present constituted is too limited, and that it has frequently been deceived by fraudulent representations. For instance, one person was registered in virtue of a diploma in which the name was manifestly altered, as was subsequently proved by a communication from the college of physicians from which it was originally issued. Other instances were given in which men were placed on the register on the production of diplomas relating to other persons and the assumption of their names. It has also been shown that persons have been placed on the register of medical practitioners in virtue of diplomas which were valueless so far as they indicated that the persons named in them possessed any medical knowledge. Some of these have been obtained from fraudulently-constituted colleges in the United States, without proof of study or successful examination, or even the presence of the candidate in America; others have been issued by colleges in that country which, though recognised by the Illinois Board of Health (the highest authority in

the United States) as fulfilling its requirements as to the length and course of study required of the candidates, are so managed that men who are quite unfit are granted diplomas after most carelessly conducted and inadequate examination. It has been further shown that when the name of any person has been once placed on the Medical Register, notwithstanding that it has been placed there through fraudulent representations on the part of the applicant, there is no means of legally removing it; and it appears that there are men registered here whose names have been struck off the rolls of the colleges from which their diplomas have been obtained as a consequence of a conviction for felony or other proved gross misconduct, yet their names, having been once placed on the register, must continue on it. We also regret to find that, although applications have been made from time to time by the Medical Board for assistance in prosecuting cases of fraud, the Crown Law officers of the colony have in no single instance given it any aid in its endeavours to protect the public. The evidence given by unqualified practitioners who have been examined shows that the confidence placed in them by a large proportion of the public is not justified by evidence of their possessing professional skill or knowledge. This is manifest from the examination by the committee of Messrs. Bottrell, Moore, Fawcett, Nash, Bethel, and others, who, though they have received no training by any qualified teachers and have not been students of any school of medicine, are, it is evident, consulted by a large number of persons who are unaware of the very superficial character of their medical attainments. Besides the men who are practising without diplomas on their own behalf, it has been shown to the committee that it has been a practice of some designing and unscrupulous men to employ registered medical practitioners as a cloak to their nefarious proceedings. These practitioners, who may have been unable to succeed in ordinary practice from their want of strength of character, mental capacity, or drunken habits, have allowed their names to be made use of and have been advertised as having special capacity and skill in certain diseases, principally those affecting the sexual organs. How nefarious the conduct of such men is is forcibly shown by the examination of John O'Connell, L.A.H. Dublin, and the witness, William Nicholas Richards, M.R.C.S., who was apparently so weak-minded, or so conscious of his culpability, that he repeatedly declined to answer questions on the ground that his answer might lead to criminal proceedings being taken against him. Under the cloak of these men's names the men who employ them extort considerable sums of money from credulous persons. We think that such conduct should be made punishable by law. It appears to us that in most instances the advertisements which are so frequently inserted in the newspapers of the colony are a tissue of misrepresentations, and that they in many instances lay the persons who insert them open to charges of obtaining money under false pretences from people who are so foolish as to consult the advertisers. But though this may be the case, we think that practically there is no possibility of punishing the offenders, for there is a natural aversion on the part of the dupes to bring their imbecile action under public cognisance by initiating legal proceedings against the persons who have cheated them. Considerable cunning (it can hardly be dignified by the term caution) has been exhibited by many of the irregular practitioners in the designations under which they carry on their proceedings, calling themselves clairvoyants, herbalists, specialists, consulting chemists, dermopathists, P.M.D. (prescriber of domestic medicine), homoeopathists, H.M.D., &c. &c., when not

assuming those of surgeon, physician, or doctor of medicine. The explanation given by the professionally uneducated men examined as witnesses as to the meaning which they apply to the term "specialist" when used by them in their announcements was that they treated special diseases. In legitimate medical practice the term is used as designating a practitioner who, having the usual knowledge of general diseases, has devoted special attention to those of one character, and it is thus we believe generally accepted by the public, who, by these announcements, are deceived into the belief that these ignorant men have a knowledge of disease generally, and have received special training in those diseases as to which they advertise. It appears that some chemists are in the habit of issuing pamphlets and other advertisements in which they profess to have unusual skill in the treatment of disease. As they place M.P.S. (Member of the Pharmaceutical Society) after their name, unthinking people may be led to believe that under the auspices of this society instruction is given in the pathology and treatment of disease, and that a certificate of membership of the society is granted after examination in such subjects. That this is not the case is shown by the evidence of the secretary, Mr. Pinhey. We have also found that it is a practice of some chemists to advertise that a properly qualified medical practitioner may be consulted at their shops, the name of such practitioner not being given. In this way great opportunities are given for the abuse of the confidence of the public, who, no name being mentioned, are very liable to be deceived as to the qualifications of the person whose advice they seek and we are of opinion that this system of practice by anonymous persons should not be permitted. Though perhaps not included in the direct scope of our inquiry, it has come under our notice that individuals who are practising as medical practitioners without legal qualifications have been appointed to the office of coroner for the districts in which they reside. We are of opinion that the appointment of such men to such offices is eminently perilous to the administration of justice and to the detection of crimes against life. We desire to point out that though we believe the appointment of a gentleman, who has received a thorough professional training in medicine and its allied branches, as coroner is eminently advantageous in such places as justify his sole employment for such a purpose, we think that the appointment even of a legally qualified medical man, if in active practice, to such an office, is undesirable, for if in a country district, he should happen to be the only medical practitioner, he would render greater service to the colony as an expert medical witness than as the coroner making the inquiry; whilst, should he be one of several, it is an invidious position in which to place him with regard to his professional brothers, who may be his rivals in his ordinary practice. And we submit that if this be the case with qualified medical men, it is much more to be deprecated when the coroner is an unauthorised practitioner, who must feel every day of his life his inferiority to the men whom from time to time he has before him as witnesses. The Medical Board should be reconstituted, and it should be provided that the members should only hold office for a term of years, instead of for life as at present; that they should be appointed conjointly and in equal proportions by the Government, the senate of the University and by election by registered medical practitioners; that the board should have power to suspend its judgment as to the registering of diplomas presented to it for that purpose, should it consider that insufficient proof of the value of such documents, or the identity of the applicants be not forthcoming, and that it should have

power to remove such names from the register as have been placed upon it through misrepresentation or fraud. We also think it desirable that the board should have authority to make inquiry as to the conduct of medical practitioners who, though rightly placed upon the register, have by previous or subsequent misconduct rendered their continued recognition as legally qualified medical practitioners a peril to the public well-being and, if necessary, to remove them. The necessity for some such provision as this is shown by the examination of the witnesses, William Nicholas Richards, M.B.C.S., and of John O'Connell, L.A.H., Dublin. Power to do this is possessed by the General Council of Medical Education and Registration of Great Britain, and is also exercised by the councils of the various licensing bodies in the mother country. We are not prepared to recommend that any person should be prohibited from practising medicine, but we most emphatically declare that it is not only just but essential to the safety of the people that no person whose name is not included in the list of medical practitioners should be allowed to give himself any title which would lead individuals requiring the services of a medical man to regard him as legally qualified. We recommend therefore, that provision should be made that no person should be allowed to assume the title of physician, surgeon, or medical practitioner, or the letters which are usually taken to indicate the possession of the degrees or licenses of the various examining bodies, unless he is registered by such medical board. In addition to this prohibition of the assumption of titles by unregistered persons, we earnestly suggest that any person who, not being registered by the Medical Board, practises as a medical practitioner of any kind, under any description, shall be obliged to place after his name and designation in all his announcements the words "unregistered by the Medical Board," these words being understood to mean that he has not exhibited the proof of fitness to practice medicine which the Board requires. In order to render this provision effective, it will be necessary to provide that every person who practises medicine for gain shall place upon the house or premises at which he carries on his calling, in some conspicuous place open to the public view, a plate or other announcement, containing his name, and some intimation that he is a medical practitioner in actual practice. We think it possible that there may be amongst the persons (nearly 200 in number) practising without qualifications in this colony some few who have acquired such an amount of medical knowledge as would have enabled them to have passed the examinations necessary to obtain the diplomas of some of the licensing bodies of the United Kingdom and that they were prevented from doing so by some unfortunate circumstances beyond their control. To meet these cases and also to remove the possibility of those who would, were the test not open to them, though absolutely ignorant, inevitably claim vast knowledge, from having the excuse of asserting that they were not only willing, but prepared to prove their capability, we would recommend that provision should be made for the admission to an examination of a practical yet sufficient character of such men as had been practising medicine in New South Wales in a reputable manner, though without qualifications, during a period of not less than five years. The names of the persons who successfully pass such examinations should be placed on a separate register, and they should be entitled to all the privileges of registered medical practitioners, except that they should announce themselves as registered under the special section of the Act under which they were accorded the favor of examination. We desire to es-

pecially call attention to the evidence of the Registrar-General in relation to the receipt of certificates as to the cause of death from men having no qualifications. Though, as is stated by him, the Registration Act is so defective that no certificate as to the cause of death is requisite prior to the registration of the death or burial of a body, yet he, in his evidence, says it has been the practice to receive these certificates from any person, and that such documents had been accepted from Messrs. Moore, Fawcett, Nash, Cathcart, McMahon, Bethel and others whose examination by the committee shows that they are in no way fitted by training to give such certificates if the documents are to be of any real value. Unless some strict rule is created as to the persons from whom certificates as to the cause of death shall be received, one of the strongest means of protection of life against secret crime, especially against criminal poisoning, is neglected. Certificates as to the cause of death have been received by the Registrar-General and his subordinates from an irregular practitioner named Sheridan, who has since been convicted and sentenced to 15 years' penal servitude for having caused the death of a woman by performing an unlawful operation upon her, and who was committed for trial in three other cases where death ensued as a consequence of his criminal proceedings. In these instances, but for the accident of a registered medical practitioner having, in one of them, being called in, and information having thus being given to the police, the certificates of this criminal would have been received and his crimes probably concealed. The evidence which we have before us on the several points for inquiry is of so startling a character and the truth and magnitude of the evil so unquestionable that we do not think it necessary to call further witnesses, having already, we believe, procured ample testimony of some of the great evils now rampant in the colony. We desire to express our earnest opinion that the evils are so great and of such vast moment to the whole population that it is urgently necessary that legislative action for their remedy should be promptly taken, and that any bill for the purpose should be introduced by the Government, it being of too momentous a character to be fittingly brought forward by a private member, independently of the fact that, with the present arrangements for the conduct of public business in the Legislative Assembly, it would probably be months before a measure of the necessary character could be passed in that Chamber unless brought in under Government auspices. In this opinion we do not stand alone. In recapitulation, we may say that, though the evils are so numerous and of so dangerous a character, we are of opinion that they would be in a great measure remedied by an Act which would provide for the appointment of a medical board, as suggested in an earlier portion of our report, the members holding office for a term of years only. The board should have power to demand proofs of identity, course of study and value of the diplomas of the applicants; to remove names of persons who have been registered through misrepresentation; and, on proof of professional misconduct, to call on registered practitioners to show cause why their names should not be removed from the register, and, on failure, to remove them for a time or permanently, according to the magnitude of the offence. The Act should provide that no person who is not registered shall assume any title or designation likely to deceive the public as to his being a qualified medical practitioner, and should give power to the board to frame regulations for carrying out the provisions of the Act, and, through its officers, to recover the penalties consequent on breaches of the Act or of the regulations under it.

REVIEW.

AN INQUIRY INTO THE CAUSES AND EFFECTS OF THE VARIOLÆ VACCINÆ, A DISEASE DISCOVERED IN SOME OF THE WESTERN COUNTIES OF ENGLAND, AND KNOWN BY THE NAME OF THE COW POX.

By EDWARD JENNER, M.D., F.R.S., &c.,
SECOND EDITION. LONDON: 1800. RE-
PRINTED BY AUTHORITY: GOVERNMENT
PRINTER, SYDNEY.

WE have recently received from the New South Wales Government Printer a copy of the reproduction by him of the second edition of the immortal Jenner's treatise on "The Variolæ Vaccinæ." This edition bears the date of 1800 and the late Sir Alexander Stuart did a substantial service to preventive medicine when he authorised its issue. Anything which tends to diffuse accurate information as to vaccination, and to remove ungrounded prejudice against its use, must be of public service, and nothing will do this more effectually than the study of the careful and accurate observations of the discoverer, in his own words. The work is introduced by the following preface:—"The original work by Dr. Jenner on the Cow Pox, published in 1799, and a second edition, enlarged, containing all his original observations on the variolæ vaccinæ in 1800, being now of great rarity—Dr. G. Bennett (of Sydney), having a copy of the second edition of the work, waited, with Dr. Mackellar and Dr. Creed, upon the Hon. A. Stuart (the Premier), to request the Government of New South Wales to reprint the book. This application was granted and a perfect facsimile of the work, in size, paper, type, and the four coloured plates, has been produced. The book will no doubt be found of great benefit to the medical profession and the general public, by placing before them, without extraneous matter, the evidence upon which vaccination was adopted by every civilised Government in the world."

The work is of so much interest that we recommend our readers to secure copies of the limited edition which has been published.*

* This work may be obtained from Mr. L. Bruck, Medical Publisher, Sydney, at 24s. a copy.

THE MONTH.

NEW SOUTH WALES.

THE Select Committee of the Legislative Council appointed on September 21 last "to inquire into the state and operation of the laws now existing for the regulation of the practice of medicine and surgery in New South Wales," have brought up their final report, which will be found in this issue.

SIR HENRY PARKES, in the Assembly on November 24, promised Dr. Ross to take the necessary steps to obtain from the Health Officer a report as to the influence of ringbarking on public health, and its effect in producing climatic changes and variations in rainfall, but he hoped it would not involve a tour on his part to all the districts of the colony where ringbarking had taken place.

THE Registered Medical Practitioners' Bill, introduced by Dr. Cortis, was discharged from the business-paper of the Assembly on November 29, as it was found that the Bill exceeded the order of leave.

In the Central Criminal Court, Sydney, on November 24, before His Honor Mr. Justice Innes, "Dr." Mary Young and Elizabeth Morales, alias Madam Sibily, were found guilty of malpractices on a woman named Elizabeth Dunstan. Young was sentenced to three years' and Morales to 18 months' imprisonment in Darlinghurst gaol.

THE "Dairies Supervision Act" is to come into operation in the municipal district of Hamilton, on January 1.

A CHINAMAN died on November 30, at Botany, near Sydney, from the effects of a snake-bite; another death from snake-bite occurred near Cooma on November 26.

DR. F. M. BLACKWOOD, late of Michelago, has removed to Cooma, where he has succeeded to the practice of Dr. E. Florance, who has gone to Victoria.

DR. M. L. BUTLER has settled at Casino, on the Richmond River, 385 miles N. of Sydney.

DR. EDWD. J. JENKINS, M.A., M.D. (Oxon.), M.R.C.P., M.R.C.S., L.S.A. (London), has been appointed "Clinical Medical Tutor" at The Prince Alfred Hospital, Sydney.

DR. G. C. MACDONALD, recently arrived from London, has commenced practice as a Consulting and Operating Surgeon at 228 Macquarie st, Sydney.

DR. R. MORROW, of Ashfield, has removed to Hillston, in a pastoral district, 435 miles W. of Sydney.

DR. M. D. MURPHY, late of Hillston, has commenced practice at Bega, in a dairy-farming district, 255 miles S. of Sydney.

DR. W. MORRIS has resumed practice in Sydney, at 63 Castlereagh-street.

DR. E. H. L. PRATT, late of Marrickville, and formerly of Tamworth, has settled at Lismore, on the Richmond River, 357 miles N. of Sydney.

NEW ZEALAND.

DR. W. S. W. ROBERTS, House Surgeon of the Dunedin Hospital, has resigned his position. The resignation was accepted by the hospital trustees with regret.

DR. M. H. PAYNE, of the Thames (Prov. Auckland), was thrown out of his buggy the other day, and sustained a nasty cut over the right eye.

DR. F. B. HUTCHINSON, of Wellington, has been awarded a prize for a set of six portrait photographs at the annual exhibition of the Wellington Fine Arts Association.

QUEENSLAND.

THE Queensland Medical Board have decided that in future the personal attendance of all candidates for medical registration will be required at the Board meetings, held in Brisbane on the first Thursday in each month.

THE R.M.S. "Dacca" arrived at Cooktown on December 6, from London. The Surgeon-Superintendent in charge of the immigrants reported that there had been 36 cases of measles on board from October 23 to November 21. The Health Officer at Cooktown granted her pratique, as no case of measles had occurred since the 21st ultimo.

DR. W. S. GEDDIE, a new arrival, has commenced practice at Gympie.

DR. K. I. O'DOHERTY, formerly of Brisbane, and late of Sydney, but now practising at Croydon, had a narrow escape from sudden death when out in a buggy early last month; the horses having bolted, his trap was run against one of the iron telegraph posts and Dr. O'Doherty was thrown several feet in the air, fortunately alighting on a small sand-ridge and escaping unhurt. The force of the shock was such as to bend the telegraph pole nearly double, and the buggy was considerably damaged.

A DEATH from snake-bite occurred near Beenleigh on December 1.

DR. W. P. B. GOODRIDGE has commenced practice at Maryborough.

SOUTH AUSTRALIA.

At a meeting of the Central Board of Health, held on November 29, a letter was received, through the Chief Secretary, from Mr. Stewart, Colonial Secretary at Hongkong, in reply to a recommendation of the Board that all passenger vessels from Hongkong to Port Darwin be required to carry a duly qualified medical practitioner. Mr. Stewart stated that small-pox was not prevalent at Hongkong, there having been no epidemic of it, and only two sporadic cases having occurred during several months. He stated also that no ship can leave Hongkong without a medical practitioner qualified to the satisfaction of the Colonial Surgeon; and that the attention of the latter had been specially directed to the Board's recommendation. The President said that Dr. Wood, Health Officer at Port Darwin, who was in Adelaide, had that day called at the office, and during a long conversation on quarantine matters he had stated that no vessels from Hongkong carry a duly qualified medical practitioner, but that they all carry a Chinese doctor, who understands no English, and from whom no information could be obtained. The Chief Secretary to be informed that in the opinion of the Board the fact that vessels carry a Chinese doctor is not a sufficient protection to Australian ports.

THE Minister of Education has forwarded to the Central Board of Health a telegram from the Government Resident in the Northern Territory suggesting that the duration of quarantine be reduced from twenty-one to fifteen days; that European officers and passengers from Hongkong be allowed to land from vessels having no disease on board without performing quarantine; and that the doctor who boards a ship for purposes of inspection be allowed to again land, even if he

find disease on the ship. The Board determined to recommend that twenty-one days quarantine from day of embarkation be adhered to with respect to all Asiatics; that European officers and passengers arriving at Port Darwin under conditions mentioned in the Government Resident's telegram be allowed to land, all clothing and other personal effects to be thoroughly disinfected, and that while there is only one medical gentleman available at Port Darwin he be allowed to land after inspection, on the condition that proper precautions be taken by means of efficient disinfection.

DR. JOHN CRAWFORD, of Teetulpa, was at the Criminal Sittings of the Gladstone Court, on November 25, sentenced to seven years' imprisonment for assaulting a female patient, aged 11 years. The prisoner is suffering from rheumatism or he would have been ordered a whipping.

TASMANIA.

AN action brought by William Free, against the Board of Management of the Hobart Hospital, claiming £2,000 damages for alleged mal-treatment whilst a patient in the institution, was tried in the Supreme Court, Hobart, on November 16, resulting in a verdict for the defendants.

VICTORIA.

Drs. CUTTS, HENRY, GRAHAM, RUDALL, ROWAN, and SPRINGTHORPE have been elected to represent the Victorian Branch of the B.M.A. upon the provisional committee of the Intercolonial Medical Congress, to be held in Melbourne in 1890.

THE first meeting of the provisional committee of the Intercolonial Medical Congress of Australasia was held in Melbourne on December 7, when it was unanimously resolved that the second session of the Congress be held in 1890, the exact date to be subsequently fixed.

AT a recent meeting of the Melbourne University Council the lecturers for the present year were re-elected, with the exception of Dr. Jamieson, who was appointed lecturer in the theory and practice of medicine, in the place of Dr. Bird (resigned), and Dr. Balls-Headley, who was elected a lecturer in obstetrics, in the place of Dr. Jamieson.

AT an adjourned meeting of the Melbourne University Council, on November 21, a letter was read from the management of the Alfred Hospital stating that the managers did not consider it desirable to reserve any department exclusively for lady students, but were willing to give clinical and out-door practice to lady students. It was stated that the management would afford every facility in their power to lady students.

AN outbreak of diphtheria has occurred at Terang, 134 miles S.W. of Melbourne.

DR. THOS. BARKER, late of Queenscliff, has removed to Lorne, a favourite watering place on Loutit Bay, 105 miles S.W. of Melbourne.

DR. W. H. BARKER, late of Mintaro (S.A.), has commenced practice at South Yarra, a suburb adjoining Melbourne.

DR. C. A. GRIFFITH has commenced practice at Gordon-street, Elsternwick, near Melbourne.

DR. J. C. MCKEE has been appointed Analyst for the borough of Eaglehawk.

DR. G. R. LAWRENCE has settled at Balmoral, 252 miles W. from Melbourne.

DR. W. B. RANKIN, of St. Kilda, was thrown from his buggy on December 1, and dislocated his shoulder.

HOSPITAL INTELLIGENCE.

THE necessity of completing the new Sydney Hospital buildings, the erection of which has been commenced in Macquarie-street, was on November 16 again impressed on the Premier by the Hospital Board, who protested against the removal of the hospital outside the city, as had been suggested. Sir Henry Parkes expressed himself as personally in favour of the present site, and promised to lay the matter before his colleagues.

At a recent meeting of the Board of Directors of the Sydney Hospital, Drs. Tarrant and Brady were appointed representatives of the honorary surgical and medical staff on the Board of Directors.

THE Inspector of Charities, visited the Goulburn Hospital, N.S.W., on November 26, and made the following memo:—"There is a general air of dinginess throughout the institute, suggesting the necessity for a thorough cleaning and whitewashing." The new hospital will not be completed for two years.

THE new hospital at New Plymouth, Taranaki, N.Z., was opened on November 8.

A NEW operating theatre, to cost £448, is now being erected at the Brisbane hospital.

A COTTAGE hospital is now being built at Barcaldine, the present terminus of the Queensland Central Railway, 358 miles W. of Rockhampton. It is to be called the "Victoria Cottage Hospital."

OBITUARY.

GEORGE CROSLAND.

WE regret to have to announce the death of George Crosland, M.R.C.S.E., 1851; M.D. Aberd., 1852; M.D. (a.s.g.) Melb. 1863, who died at his residence, Epsom Downs, near Bridgewater-on-Loddon (Victoria), on November 22, from a tumorous swelling in the throat. He was 60 years of age, and was a very old resident of that district; many years ago he held the position of Surgeon to the Inglewood hospital.

THOMAS SERRELL.

WE have also to record the death of Thomas Serrell, L.S.A. Lond., 1829, late of Fitzroy (Melbourne), who died at Whittlesea (Victoria), on November 28, at the ripe age of 80 years.

BIRTH.

HARWOOD.—October 16, at Windermere, Boscombe Park, Bournemouth, Hampshire, the wife of S. Soutter Harwood, M.D., L. et L. Mid., K.Q.C.P. Irel., of a son.

MR. L. BRUCK, 35 Castlereagh street, Sydney, has just received a supply of Wyeth's Compressed Test Tablets for preparing Fehling's Solution of Potassio-Cupric Tartrate; price 3s. a box, postage paid.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Orr, Andrew William, M.B. T.C. Dub., 1887; L.K.Q.C.P. Irel., 1887.
 Boyd, Robert John, L.R.C.P. Edin., 1890; L.R.S. Edin., 1890.
 Furnival, Francis Henry, L.S.A. Lond., 1883; M.R.C.S. Eng., 1883.
 Barcroft, Alfred Ernest Jaffray, L.K.Q.C.P. Irel., 1888; L.R.C.S. Irel., 1884.
 Todd, Robert Henry, M.B., 1886, M.D., 1886, Ch.B., 1886, Diploma in State Health, 1886, T.C. Dub.; F.R.C.S. Irel., 1887.
 Mullins, George Lane, M.B. Univ. Dub., 1887.
 Watt, Alexander Kinnear, L.S.A. Lond., 1886.
 Macdonald, George Childe, L.R.C.P. Edin., 1883; M.R.C.S. Eng., 1884; F.R.C.S. Edin., 1887.
 Dunlop, John James, M.B. Univ. Glasg., 1883; M.S. Univ. Glasg., 1883.
 McCoy, Thomas Joseph, L.K.Q.C.P. Irel., 1876; L.R.C.S. Irel., 1874; L. Mid. K.Q.C.P. Irel., 1876.
For additional registration:—
 Goode, William Henry, M.D. T.C. Dub., 1878; L. Mid. K.Q.C.P. Irel., 1878; Diploma in State Medicine, 1877.
 Lane, Thomas, L. Mid. K.Q.C.P. Irel., 1883; Diploma in State Medicine K.Q.C.P. Irel., 1883.
 Paton, Robert Thompson, F.R.O.S. Edin., 1887.

QUEENSLAND.

Connolly, Frank Glynn.
 Paul, George William Frederic.
 Goodridge, William Pope Baldwin.
 Fitzgerald, Joseph, L.R.C.S. Irel., 1871; L.K.Q.C.P. Irel., 1873.
 Watson, Arthur, M.D., 1879; M.B. et Ch.M. Edin., 1874.
 Holcroft, Henry, M.R.C.S. Eng., 1883.
 Geddie, William Stewart.

TASMANIA.

Lawrence, Henry, M.R.C.S. Eng. of L.S.A. Lond., 1860; L.R.C.P. Lond., 1867.

VICTORIA.

Barker, Walter Herbert, M.R.C.S. Eng., 1875; L. et L. Mid. R.C.P. Edin., 1880.
 Webb, Malcolm, M.D. Lond., 1894; M.R.C.S. Eng., 1883.
 Astles, Harvey Eustace, F.R.C.P. Edin., 1879; M.D. St. And., 1883; M.D. Adelaide, 1886, (a.s.g.)
 Jarmitte, Charles Gower, M.R.C.S. Eng., 1886; L.S.A. Lond., 1886.

MEDICAL APPOINTMENTS.

Barker, Walter Herbert, M.R.C.S.E., L.R.C.P. Edin., to be a Junior-Deputy Medical Superintendent, Hospitals for the Insane, in Victoria, for six months on probation.
 Hayes, James Bennett, L.R.C.P. et R.C.S. Edin., to be Health Officer for Smythesdale, Victoria.
 Houston, James, M.D., Ch.M., to be Government Medical Officer and Vaccinator for the district of Grafton, N.S.W.
 Lawrence, George Richard, M.R.C.S.E., to be Public Vaccinator at Balmoral, Vic.
 MacLennan, John Norman Emalie, M.B. et Ch.M. Aberd., appointed Resident Medical Officer at the Sick Children's Hospital, Glebe (Sydney).
 Pockley, Francis Antill, M.B. et Ch. M.Hd., M.R.C.S.E., appointed Hon. Asst. Ophthalmic Surgeon, Prince Alfred Hospital, Sydney.
 Roberts, Shirley, M.R.C.S., to be Public Vaccinator at Moonambie and Redbank, Victoria.
 Sisco, Natalie, M.D., to be Public Vaccinator at Mt. Egerton, Vic.
 Wall, Maximilian Eugene, M.D., to be Health Officer for Colac, Victoria.

REPORTED MORTALITY FOR THE MONTH OF OCTOBER, 1887.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Group and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Bronchitis.	Pneumonia.
N. S. WALES.														
Sydney	135,000	294	146	52	1	...	2	1	...	5	13	10	5	10
Suburbs	200,000	776	326	158	6	5	5	2	10	19	27	24	15	13
NEW ZEALAND.														
Auckland	35,965	121	27	13	...	...	1	...	...	1	2	...	2	1
Christchurch	15,684	42	13	2	...	...	2	...	...	...	2	1	1	...
Dunedin	24,233	59	26	5	...	...	...	...	...	...	4	1	4	1
Wellington	26,956	99	26	10	...	...	1	3	...	...	4	3	4	1
QUEENSLAND.														
Brisbane	32,571	116	38	23	}	...	2	1	2	80	7	7	1	3
Suburbs	41,082	178	90	58										
SOUTH AUSTRALIA.														
Adelaide	310,635	882	246	76	...	1	4	1	2	4	29	20	10	19
Adelaide	42,904	105	63	12	...	...	...	...	...	2	11	5	2	8
TASMANIA.														
Hobart	31,258	84	63	8	...	...	5	...	3	...	5	4	3	5
Launceston	19,602	66	42	9	...	...	...	...	1	...	4	3	1	...
Country Districts	89,712	263	77	...	...	...	...	2	...	...	...	...	...	...
VICTORIA.														
Melbourne	69,774	130	76	} 181	19	...	10	1	5	15	58	28	20	36
Suburbs	275,606	929	431											

METEOROLOGICAL OBSERVATIONS FOR OCTOBER, 1887.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.			Depth.	Days.		
Adelaide—Lat. 34° 55' 33" S. ; Long. 138° 36' E. ....	...	90.5	61.8	43.2	29.904	Inches	...	...	...	...
Auckland—Lat. 36° 50' 1" S. ; Long. 174° 49' 2" E.	140.72	56.2	40.4	...	30.240	...	20	83	...	...
Brisbane—Lat. 27° 28' 3" S. ; Long. 153° 16' 15" E.	138.90	68.5	50.6	30.088	4.824	22	64	N.	...	...
Christchurch—Lat. 43° 32' 16" S. ; Long. 172° 38' 59" E.	143.79	53.2	32.2	...	3.772	10	64	...	...	...
Dunedin—Lat. 45° 52' 11" S. ; Long. 170° 31' 11" E. ....	...	...	...	...	...	...	...	...	...	...
Hobart—Lat. 42° 53' 32" S. ; Long. 147° 22' 20" E.	82.5	55.5	36.5	29.829	1.85	12	80	...	...	...
Launceston—Lat. 41° 30' S. ; Long. 147° 14' E.	75.5	56.4	34.9	29.887	2.36	12	71	...	...	...
Melbourne—Lat. 37° 49' 54" S. ; Long. 144° 58' 42" E.	82.1	56.8	38.1	29.882	2.83	11	...	...	...	...
Sydney—Lat. 35° 51' 41" S. ; Long. 151° 11' 49" E.	94.3	63.8	47.6	29.975	1.36	12	63	N.E.	...	...
Wellington—Lat. 41° 16' 25" S. ; Long. 174° 47' 25" E.	131.71	52.2	36.2	...	8.237	19	78	...	...	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

ON THE HISTOLOGICAL PREPARATION OF TUBERCULAR SPUTUM.

By F. W. ELSNER, F.R.C.S.I.

HAVING been frequently asked by friends to detail the best method for obtaining Koch's bacillus, in the sputum, tissues, &c., I thought that the *A. M. G.* might find space for the following description of the method I adopt in examining specimens of sputum for diagnostic and prognostic purposes. There is and can only be one *original* method, and that is Koch's; but there are numerous modifications, and every investigator will pick up a hint from this or that writer's description which he has found carries him quickest to his object, and therefore adopts. Very seldom in the literature of the subject do we find two writers give the same version of what is Koch's method, but those interested in the subject will find it fully and, of course, correctly detailed in that memorable issue of the *Berliner Klinische Wochenschrift*, No. 15, for 1882, in which Koch's paper (as read on the 24th of March of that year, before the Physiological Society of Berlin) is published from his own MS. He used methyl-blue and vesuvin as a contrast stain, but now methyl-violet is almost exclusively used, and fuchsin is also mentioned as Koch's own selection, but not in his first communication. The method I shall now detail is a combination of the Koch-Ehrlich methods, with Biedert's method for finding bacilli when these are not numerous enough to be detected quickly by the ordinary method.

The histologist who wishes to find bacilli in sputum, etc., must provide himself with a good microscope having an oil immersion lens, giving a magnifying power of at least 1000 diameters; for a high power such as this, an Abbé's illuminating apparatus is indispensable. Leitz, of Wetzlar, provides such a microscope for M. 300 (£15), and various English makers also furnish similar instruments, but at very high prices. The

microscope *par excellence* is that of Zeiss, of Jena, whose lenses are, without exception, the best and, at the same time, the cheapest as such. I have had my microscope specially made for me by Zeiss, and although no work or expense has been saved, it has only cost about fifty guineas, and is really a triumph of the maker's art. I have four oculars and three lenses (AA, DD, and 2.0m.m. oil immersion, or $\frac{1}{12}$ in.), and with No. 12 ocular and $\frac{1}{12}$ objective, I get a magnifying power of over 1,500 diameters, which enables me to find a bacillus in a few seconds if one exists upon the slide. I have no doubt that Mr. L. Bruck can furnish any gentleman with whatever he requires in the microscopical line, and at moderate prices. The Melbourne agents for Zeiss are Weiller and Heidepriem, of Queen-street, who have all the particulars; and I believe an optician of Melbourne has, some time since, ordered a large variety of these microscopes, which will soon be in the market therefore. I doubt whether old stands can be fitted with Abbé's illuminator out here. I fancy it is more satisfactory to have the whole group of apparatus of one pattern, as it saves expense in the long run. However, that is a matter which can be left to each individual's fancy, and we will assume, therefore, that the optical apparatus is in order and of the requisite magnifying power; the further requirements are: some watch-glasses, an evaporating dish or two, a few glass funnels, filter paper, and c.c. measuring glass, a spirit-lamp or Bunsen's gas burner, a small tongs, and a platinum pointed forceps for holding cover glasses. If the histologist possesses a platinum needle, he will now be almost completely fitted out. Of solutions he will require:

1. A saturated solution of methyl aniline violet (Martindale's is the best obtainable in Australia) in spirit, and a saturated aqueous solution of Bismarck brown, with a crystal of thymol in it to preserve it, as all the aniline solutions are unstable if not containing spirit; the solutions should always contain an excess of the dye.
2. Dilute nitric acid (about 1 in 3).
3. Purified aniline oil, methylated spirit, alcohol (60 %), absolute alcohol, caustic potash (40 %), and distilled water.
4. Oil of cedar, having an index of refraction $n_D = 1.515$ for the immersion lens (this is always furnished by Zeiss himself for his own lenses and no other should be used), and Canada balsam in Benzol.

The steps to follow in examining sputum for bacilli are:

Firstly.—Preparation of the staining fluid for the bacilli, which consists in agitating 100 c.c.

of distilled water with 5 c.c. of aniline oil for half-a-minute, allowing it to stand for five minutes and then passing it through a filter previously moistened with distilled water. As this aniline water does not keep long, it will have to be freshly prepared every week or so; 5 per cent. of alcohol is a useful addition to preserve the fluid. Filter into a watch-glass some 10 or 12 drops of aniline water, and add from 4 to 6 drops of the methyl-violet solution, and you have the bacillus staining fluid.

Secondly.—Preparation of the contrast or ground staining fluid, which consists in filtering into a watch-glass half full of distilled water, sufficient of the aqueous solution of Bismarck brown to darkly colour the water without destroying its transparency.

Thirdly.—Preparation of the cover-glasses: A well-cleaned pair of glasses is selected, and from the lowest stratum of the sputum a tiny portion is withdrawn by the platinum or ordinary needle, previously sterilised by heating in the flame of the spirit lamp; this is spread out a little upon the cover-glass, the second one is laid upon this, pressed out, the exuding fluid wiped off with clean blotting paper, and then, by drawing asunder (not lifting) the glasses, we get a thin layer of sputum, evenly spread, which is allowed to dry in the air but protected from dust. When dry, these glasses are drawn through the flame of the spirit lamp three times, armed side uppermost, whereby the albumen is coagulated and the sputum baked to the cover-glass. This should occupy 3 seconds, after which the cover-glass is swum, armed side under, on the methyl-violet solution, which is held over the flame until bubbles begin to rise. As beginners will always break some dozens of watch-glasses in this way, I would recommend them to boil their violet solution in a test tube first and pour it into the watch-glasses previously warmed, then float the cover glasses on the fluid whilst they are still hot from the coagulating process, and let them swim for at least 10 minutes. The watch-glass may, if preferred, be heated in a sand-bath.

Fourthly.—Remove the cover glass from the violet solution and float it on a watch-glassful of nitric acid solution for 5 seconds, then rinse in distilled water to restore the colour.

Fifthly.—Rinse in a watch-glass of 60% alcohol until no more colour can be got off the film; a few seconds will mostly suffice for this.

Lastly.—Float the cover glass, as before, upon the Bismarck brown solution, to get the ground stain, for half a minute; rinse in distilled water, and examine with a high power on a slide with a drop of water, or allow it to dry and mount in Canada balsam before examining.

If these measures are properly carried out the bacilli will stand out from the other bacteria and pathological products stained a deep blue, the ground a beautiful brown. Should no bacilli be found we cannot conclude that the sputum does not contain them until we have adopted Biedert's plan, which is to boil 3ss. of sputum with 3i. of distilled water and 15 drops of caustic soda, or potash solution, until it has become liquified; another ounce of water is then added and the liquid is boiled again until a homogeneous solution in which only a few particles of undissolved sputum are seen floating is obtained. This, if on cooling, is found to be still thick, may be yet further diluted, and is then allowed to stand in beakers for 2 or 3 days, at the end of which the supernatant fluid is poured off and the remainder examined for the bacilli in the manner just described. Should all the albumen have become dissolved it may be well to add a little fresh white of egg to the film on the cover-glass before heating, to heighten the contrast.

Should no bacilli be found now, we may safely conclude that the sputum is from a non-tubercular case. The same procedure is adopted in examining the contents of abscesses, etc., for bacilli; tissues should be hardened in spirit and treated in much the same way. It is hardly necessary to add that with the exception of lepra bacilli, no other bacteria can be stained in this way; of these lepra bacilli I will report at some future time, suffice it to say now, that the history of the case and other sufficiently obvious reasons exclude the possibility of confusion therewith.

Any practitioner surely can spare time enough to carry out these particulars which, when all is in good order, do not take longer than an exhaustive examination of the urine in a case of Bright's disease, if, indeed, they occupy so much time.

It will give me great pleasure to undertake examinations of sputum in cases where there is doubt as to the nature of the lung affection, if any gentleman will send me a specimen and a few notes about the case. For the information of those who, like myself, are enthusiastic in the matter, I may add that Messrs. H. Francis and Co., of Bourke street, have all the stains, etc., in stock, as far as Melbourne is concerned, whilst Mr. L. Bruck announces that he can supply them for Sydney.

From personal experience I can affirm that no other method gives such good or permanent results as the one detailed; it will therefore save disappointment if beginners adopt it for their first attempts, and then, if they have time, try others for themselves, e.g.: Gibbes' double stain, Rindfleisch's method, Orth's, Neelsen's, and a host of others.

Church Street, Richmond (Melbourne).

ON INJURIES OF THE KNEE-JOINT.

READ BEFORE THE NEWCASTLE (N.S.W.)
MEDICAL SOCIETY,BY JOHN B. NASH, M.B. ET CH.M. ED
M.R.C.S.E.

[ILLUSTRATED.]

THE subject which forms the substance of this paper must be of importance to all general practitioners, for at any time it may be the lot of some of us to have to treat a similar case to one of the three which shall be narrated subsequently. Not only, do I apprehend, is the subject one of interest to the ordinary practitioner, but to the pathologist the surrounding and constituent tissues of the knee-joint are yet a fertile ground for research, the result of which, when added to our present knowledge, may be of incalculable advantage in the future treatment of similar injuries. Much is already known in regard to the pathological processes which follow in the synovial membrane, cartilaginous and osseous structure of a joint, after a wound has penetrated its covering, as is instanced in Mr. Barwell's elaborate and able treatise, yet much requires to be added to our present knowledge as to these processes, and as to the immediate causes of these processes; for minds imbued with the germ theory, it is easy to find a satisfactory solution for all the troubles that follow upon a wound in any tissue, by saying "through some failure on the part of the surgeon, septic germs have got access to the wound or to the joint, and the action of these Micrococci or Bacteria, be they which they may, have caused all the trouble, in fact, it is the old, old fault, failing in the first step has led to ever-multiplying trouble." This theory has a great convenience, in that it is applicable at all times, and in almost all places, as a primary cause of septic inflammatory actions; it has a further advantage, in that it is satisfying to the mind to think that one has a solution of a difficult problem in almost any emergency. To one not entirely wedded to this theory, a comparison of the second and third cases in this paper will set his mind to consider why, if in the second case, where the patient was seen almost immediately, a clean axe had caused a

slight wound into the joint, treatment had been applied at once, the utmost cleanliness had been attended to, the result so far has been anything but satisfactory, yet in the third case, where a large wound was made into the cavity of the joint, a lot of coal and other dirt got into the joint, and impregnated its surroundings, the patient was not seen for almost one hour after the injury, the utmost cleanliness and the same treatment had been applied, and the result is satisfactory beyond anticipation. I have the third patient in attendance for you to see his leg in order that you may examine his joint for yourselves, and judge as to the progress which he has made since the injury; the man corresponding to case No. 2. is still, I regret to say, in bed, with deep suppuration slowly but surely wearing his limited amount of strength away. My undergraduate ship was spent at a school in which the teachers, with but one notable exception, were thorough followers of the Listerian method of treating all lesions in which cutting of tissues were involved; naturally my mind was thoroughly abhorrent of anything that savoured of bacteria, yet, I must confess, of late I have become somewhat sceptical as to whether we have arrived at that stage in the etiology of pathological processes, at which we can put our fingers upon a finite factor and say, "there and only there have we the cause of such and such series of events." In the following portion of this paper I shall narrate, in a condensed manner, the causes of the accidents, the treatment adopted, the events which followed this treatment, unfavourable and favourable, and then I shall make some observations more or less superficial upon interesting points, principally in relation to the third case, which diverges in some points from common injuries to joints.

If a comparison of the cases be made, it will be seen that in the cause, the first and second are similar; in constitution (an indefinite but much used term), the patient in the second case was deficient in that vigour which characterised the other two; in the treatment, though the same ideas were followed in all three cases, ice was not used in the boy A.S.; it was used in E.S. as soon as there were indications of an extension of the inflammatory action beyond the synovial and cartilaginous tissues, and in J.McC. it was used from the very first.

Case 1.—A.S., æt 14 years, native of N. S. Wales. A healthy boy, the son of healthy parents.

Thursday, 8th April, 1886.—About one week before this date, while using a tomahawk cutting a piece of wood, the instrument slipped, and the sharp edge struck him upon the right leg, it cut him above the patella, and at the outer margin of

the extensor tendon. The wound was about one inch long, its lower end was one quarter of an inch from the upper border of the patella, and it extended upwards and slightly outwards.

The wound was open, the granulations were healthy, there was a little clear synovial fluid flowing from it. I did not recognise the nature of this fluid at the time, so I approximated the granulations with the three stitches, hoping that the case would do well. The granulations, though being good in size and colour, yet presented a pouting appearance which is characteristic of the existence in their centre of a sinus along which material is passing from a cavity or foreign body. In three days the joint was swollen, the stitches were tense, so I removed the silk, when immediately a quantity of synovial fluid and some pus flowed freely from the joint, this plainly showed that in the first instance the cut had reached and gone through the synovial membrane of the knee.

Synovial fluid was secreted, in large quantities, for five weeks; much pus was mixed with it in the discharge, pieces of softened detached cartilage came away frequently with the fluid and pus; during this time there was great tenderness on, and around, the joint, the slightest attempt at movement gave him great pain, and he could hardly bear to have the dressings changed. At the end of the fifth week the pain and tenderness began to diminish, the discharge decreased in the quantity of all its constituents, the ends of the bones, bared of cartilage, were approximated, and ankylosis commenced to take place; this was the result that I anticipated for the case from the first, and slowly, but surely, with the diminution in the quantity of the discharge, and in the intensity of the pain, the bones united, the tissues around the region of the joint assumed their normal proportions. At the end of the third month from the receipt of the injury he was able to get about upon crutches; at the end of the fifth month he was able to put his foot to the ground, and to walk a short distance fairly well. Since that time the bones have become firmly united and his leg is as useful as need be, following the occupation to which he has been apprenticed, viz., a shoemaker. I advised his parents to put him to learn this trade, as there is no walking required, and while at it he is not placed at a disadvantage in relation to other youths by the fact that his leg is stiff. Though during the first weeks he had elevation of temperature varying from 100° F. to 103° F., and a pulse ranging to 110 beats per minute; he at no time had any further signs of septicæmia, and when the cartilage was removed from the ends of the bones there was no attempt at softening of the bones by osteitis, nor was there any tendency to extension

of the processes of suppuration to the tissues surrounding the joint.

Treatment.—The line of treatment adopted was: 1st—To keep the leg from the hip joint downwards as immovable as possible. 2nd—To apply antiseptic dressings in the form of one in twenty carbolic oil directly to the wound, at least three times a day. 3rd—To wash the wound with cold carbolic lotion at least twice during the day. 4th—To apply as cold applications as possible. 5th—To facilitate the exit of the discharge from the joint by pressure, by keeping the wound open, and by washing out the wound. 6th—By general attention to medical treatment, and nourishing diet.

Upon the 3rd of June, of this year, or fourteen months after he cut himself I saw this boy, then his leg was a useful one, and he told me that he was getting on well with his trade, and that the leg gave him no trouble when walking or at his work.

Result.—The result was as good as could be looked for from the outset of the case.

Case 2.—E.A., æt. 25 years, native of the country. Occupation: bushman.

History.—A sober, industrious young man, accustomed to take plenty of exercise in the form of using an axe, and rowing a boat, the former in the pursuit of his ordinary occupation, the latter for pleasure. Though able to do a day's work, he would not be classed as strong, as he is wanting in muscular vigour for a man of his height, about 5ft. 9 inches, and weight about 10 stone. His mother is a small but healthy woman, of his father I have no information. Upon the morning of the 15th of February, while cutting a piece of wood with an axe, the edge of the instrument missed the wood and struck him upon the inner side of the right knee-joint, and it made a wound about two inches long over the lower portion of the joint; the cut extending from near the inner margin of the patella backwards and downwards. It was a clean incised wound of the soft parts, and it had been made but about half-an-hour when I saw it, there had been some bleeding, but none of any consequence. Owing to the relation of the wound to the knee-joint I made a careful examination with my finger and with a probe to find if the synovial membrane had been cut. I found no communication with the joint, yet I feared that such had taken place, and I warned the patient and his friends that though the injury was apparently a simple one, yet it might give him a great deal of trouble, which might keep him laid up for many months. In the hope that the joint had not been entered, or that so clean and sharp cut tissues would unite at once under an antiseptic dressing, I stitched the

edges together and applied carbolic oil, one part in ten, freely to the injured tissues. In a few days the joint filled with synovial fluid, pus began to form, his temperature rose and his pulse quickened; the stitches were at once removed, and all the fluid and pus were expressed from the joint. As in the preceding case, the quantity of synovial fluid secreted was large, the amount of pus formed was considerable, and the cartilage off the ends of the bones came away in flakes for several weeks?

After about five weeks proceeding in this manner, the suppuration gradually diminished, but instead of, as in the preceding case, going on to ankylosis, the ends of the femur and tibia underwent changes, the cancellous bone expanded and softened, and the soft tissues below the knee became oedematous; to meet this alteration ice was applied to the joint, a lotion of 1 in 2,000 of bichloride of mercury was substituted for the carbolic oil, this had the desired effect so far as the soft tissues and the external opening were concerned, as the inflammatory action in them gradually subsided, the suppuration was diminished, the wound took on a healing action, but the condition of the bony tissues was little bettered, the absorption of the calcareous matter still continued, the animal matter expanded more owing to hyperæmia and its becoming infiltrated with pus corpuscles and leucocytes a result of the spreading within it of the inflammatory process.

At the end of the second month the wound looked well, there was a little pus, (*pus bonum et laudabile*), but the knee was still very painful, the ends of the bones continued soft and thickened and there seemed to be no inclination in the parts to proceed towards repair.

As to his general condition during these two months, he has only taken his food fairly, he has slept badly, and diarrhœa has been occasionally troublesome; various drugs and other means were adopted to remedy these conditions, with more or less success. His tongue has been almost continually dry and coated, notwithstanding the efforts made to remedy the causes which were supposed to be leading to it. His temperature has seldom been above normal and his pulse has kept under one hundred per minute.

Succeeding to these phenomena, low abscess formation commenced around the joint, these accumulations of matter opened upon the surface at various points, the muscles below the knee became flaccid, the foot drooped at the ankle, and the soft tissues became oedematous. When these phenomena began to develop, and after due consultation, I advised to the effect that the leg should be amputated as almost the only hope of

saving the man's life, this advice would not be accepted; and since, a continuance of treatment with a view to sustaining his health and to counteracting the drain upon his system by the suppuration, has been followed. At the present time, i.e. six months after the accident, he is in bed, much emaciated, with the knee suppurating and his condition altogether bad. The question of excision of the joint arose when considering the advisability of recommending a radical method of dealing with the case, but upon the grounds that he was not a very robust man, that the inflammatory processes in the ends of the bone showed no tendency at any time to repair, that he would be kept much longer in bed after an excision, that his general condition demanded the most speedy means of getting him out of his room, that it would be easier for him to make a rapid recovery after amputation, we decided to recommend the amputation as the more likely method of bringing the case to a satisfactory issue.

September 26, 1887.—Since writing the above the man's general health has taken a decided change for the better, the diarrhœa has ceased, he is taking his food well, he is putting on flesh, yet the knee-joint and the leg below it, are suppurating freely, the skin has a glazed, unhealthy appearance, and we have again advised amputation, as we cannot see how the leg can ever again be of any use to him, owing to the disorganised condition of the bones and the interference that has taken place with the muscles. One would now be warranted in expecting a successful termination to an operation that would be adopted for his relief. Drs. Stapleton and A. W. Nash assisted me in attendance at and consultation over this case.

Case 3.—J. McC., æt. 43 years. Coal-miner.

History.—A man of apparently an iron constitution, who since his youth has indulged to excess in tobacco and alcohol, and in other vices which are common amongst men of his class. Yet he has not, so far, shown in any of the organs of his body, pathological phenomena, which in ordinary individuals are the customary sequence of dissipation and exposure.

March 4th, 1887.—To-day some coal fell upon him when he was at his work in the Co-operative Colliery. I saw him when he had been conveyed to his home, and I found that he had a large wound upon the inner side of the left knee-joint; upon pressing around the wound a considerable quantity of venous blood oozed out; he was so primed with alcohol that he did not recognise that his injury was a serious one, in fact he wanted me to allow him to walk about. Upon cleaning up the wound and surrounding tissues I

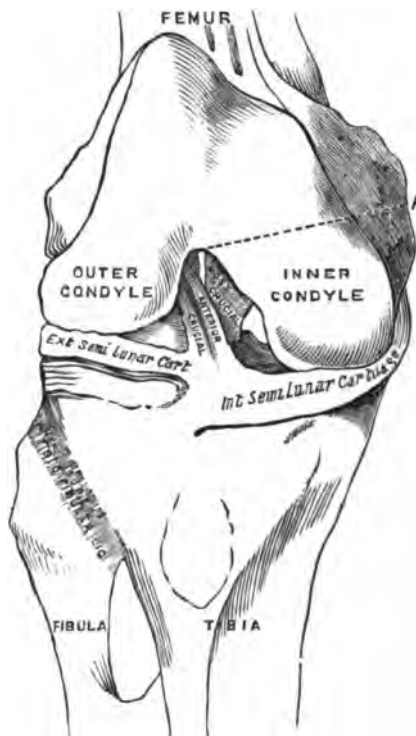
made an examination with my index finger and I found that on the surface the wound was about three inches long extending from a point two inches from the inner margin of the patella, and upon a level slightly higher than the absolute line of the joint, it extended backwards and slightly upwards and its posterior portion was over the tendons of the inner hamstring muscles, it reached a short distance up the popliteal space; that deep down there was some bone gone from the internal condyle of the femur, and I could examine the inner half of the superior articular surface of the tibia, with the semilunar cartilage lying upon it undisturbed, there was no doubt as to the joint being freely opened, and as to a piece of bone having been removed from the lower end of the femur.

I washed the parts well with warm water and carbolic lotion and in order to make a better appearance temporarily, I stitched the edges of the injured tissues together and applied to the surface carbolic oil (1 in 10) on lint, fixed in position by a bandage. When he had been made comfortable on a couch I fixed the leg slightly flexed on a MacIntyre splint, and I put a fresh dressing of carbolic oil upon the wound, I had ice applied in an ice bag constantly over the dressings upon the joint. When thinking over the case during the evening and night, I was considerably puzzled as to what had become of the piece of bone which had been broken off the lower end of the femur, and I wondered if by any chance it could be left in any portion of the soft tissues, and much relief was afforded to me next morning when a man brought to my rooms the piece of the internal condyle which I now show you, and which he said he had found amongst the coal where the accident had occurred.

I gave a very guarded prognosis, as I could not see that a good result would ensue short of an excision or an amputation. Next day, following up the line of treatment with which I had commenced, and as no tension had arisen and no sign of any irritation or inflammation was present, I did not interfere with the stitches. There was some general swelling around the joint, but there was no redness nor accumulation within the joint. He told me that after the accident he walked a few yards, this I can quite believe, as the external condyle being in proper position might suffice at the moment to carry the weight of the body on to the tibia.

Upon examining the piece of bone that was broken off and forced out of the joint, it was plainly seen to be the internal condyle of the femur, the line of fracture extending from a point on the inner tuberosity below the tubercle for the insertion of the tendon of the adductor magnus

muscle, outwards and slightly downwards to the top of the inter-condyloid notch.



This included the whole of the articular cartilage upon the posterior and under surface of the condyle and of that on the anterior surface except where it is continuous with the cartilage upon the outer condyle to form the cartilagenous surface for the patella to play upon. When the bone was first obtained, some portions of the posterior crucial ligament were adhering to it.

An interesting point to consider in relation to this piece of bone is—how did the violence in a general fall of coal come to be applied to a comparatively small point, and in a manner which, while causing the avulsion of this condyle from the end of the femur, at the same time forced it out of the joint, without apparently doing any injury to the surface with which it articulated, not even displacing the semi-lunar cartilage upon the tibia? One would expect that violence applied internally to the condyle would force it outwards and perhaps downwards, if the weight of pressure were also from above, but why a force applied to its inner surface should cause it to escape from the joint by a wound upon this surface I have not been able to imagine; moreover the opening in the soft parts through which it escaped must have been made by the same material that broke it off from the rest of the bone.

The cut in the ligaments, and it was a cut not a tear, was of no small extent to allow a piece of bone of that size to pass through; upon looking at the bone itself you can see that the only ligament attached to it was the posterior crucial, and perhaps some fibres of the capsular ligament which lie beneath the internal lateral ligament, this last mentioned ligament is attached higher up on the inner surface of the condyle.

One way has occurred to me which might be an explanation of this matter, viz.: The violence applied directly to the inner surface of the condyle may have broken it across, and then, when the leg was lifted from where it was caught, the separated piece may have dropped through the opening in the soft tissues. There are many patent objections to this view, one being that the posterior crucial ligament was torn, and to cause this in the case, some force should have acted upon the fractured bone from without inwards, and though Mr. Barwell says this ligament is only a fold of the synovial membrane of the joint, it would be strong enough to hold this portion of bone in position if it were not pulled or pressed upon; a second is, as soon as the knee was lifted the soft parts would approximate and prevent the bone from falling from the joint; there are other contra reasons which I need not pursue further. I am in want of an acceptable explanation as to why or how this condyle, with the wound in the position as indicated, escaped from the joint. The fracture having taken place below the ligamentous attachments, only the posterior crucial, and the delicate synovial membrane was left to hold it in position, these were both, as you can see, completely and entirely torn from their attachments.

To revert to the progress of the case from the day of the accident: During the first week the swelling around the joint was considerable, but there was no sign of any inflammatory action, no escape of synovial fluid, no suppuration; a small superficial slough began to form; there was some pain and restlessness, which was easily controlled by bromide of potassium in gr. 35 doses. By the fifth day all the stitches had been removed. His pulse went between ninety and one hundred, never above the latter, and the temperature kept at normal. We could not manage to keep the leg in position upon the McIntyre splint so we fixed pillows beneath it, and kept it propped latterly by sand bags, this method was found to suit very well. The same treatment was continued locally. By the end of the second week there was only a superficial sore where the skin had not come together, this was in a healthy granulating condition, though there was some infiltration at the margins. The swelling was subsiding gradu-

ally, and the only complaint that the patient had was that he could not get up and go about.

Though the progress of the case appeared to be so satisfactory, yet it gave me much concern and food for thought as to the future condition of a leg with a joint deficient upon one side, as to its superior articulating surface, and I was not even convinced in my own mind but that it would have been better at the outset to either have excised the joint or amputated the limb. For, given the wound healed, will the external condyle suffice to transfer the weight of the thigh and body above it to the tibia in a sufficiently satisfactory manner to leave the leg and joint useful to a workman? A question in physics here arises, viz., through what point in the lower end of the femur is the weight above it transferred to the upper end of the tibia? I have not seen the matter referred to in my reading, and my knowledge of physics is too limited to permit of my offering, even to myself, a solution of the problem; if I had had a scientific solution of the problem I should have been much aided in my prognosis. It was suggested to me that bony material would be thrown out from the fractured surface and that a stiff joint would result; I could not see how this could be, as there was more than an inch separating the fractured surface from the head of the tibia, and the cartilages upon the tibia were intact and in no way disturbed. Upon examining the joint now you can find that new bone has been formed at the internal condyle, but there is no stiffness of the joint (five months after the accident). The patient at this point was shown to the Society.

One month after the accident he was able to lift the thigh and leg off the bed, to move the foot at the ankle and the toes, and an attempt at flexion of the knee joint caused pain. As the wound had healed, except superficially, and there was no tendency in any of the tissues to take on an inflammatory action, the ice was discontinued and a solution of bichloride of mercury 1 in 2,000 was substituted for the carbolic oil, this change was made as the growth of epithelium from the skin margin appeared to be checked by the carbolic application. Under the lotion a firm cicatrix rapidly formed. He was anxious to get out of bed.

In three weeks more he was about on crutches, he could move the knee-joint freely, though there was a good deal of crackling felt by the hand held upon the moving joint. The knee was unshapely from thickening of the tissues and a bulging forwards of the patella. Since then, up to the present, the condition of the joint has been improving until it has reached the condition which you have seen, and it is to be hoped that a still greater improvement may take place.

A question which has frequently recurred to me is—will the joint ever be strong enough for him to work with? Besides the anatomical points which we considered as to the absence of the condyle, others of no less importance here present themselves, in relation to how far the fibrous and other tissues left and reunited upon the inner side of the joint will suffice for the support of the adjacent portion of the articulation. The piece of detached condyle was situated below the attachment of any strong ligament, then have the cut edges of the synovial membrane, of the ligaments, of the sub-cutaneous and cutaneous tissues united to one another so as to be in as strong and independent a condition as they were previous to the accident? Sir Jas. Paget in his work upon Surgical Pathology says: "After injuries about joints, the stiffness depending upon the adhesion of the scar to the deeper tissues gradually decreases One part of it assumes one character, and another part a character quite different, till at length, that which looked homogeneous, as a mass of new formed tissue, acquires in separate parts the characters of the several tissues in whose place it lies, and whose office it is destined, though still defectively, to discharge." Such being the case, will the reunited internal lateral ligament, with whatever support it may receive from adjacent parts, be sufficiently strong to keep the bones in proper position during walking and when at work? It has been suggested to me that it will not, and that when he puts any weight upon the foot the internal lateral ligament will stretch and the leg will bend outwards upon the external condyle, and it will be of little or no use to him. The line along which the weight of the body is carried from the acetabulum to the tibia being inwards as well as downwards certainly favours this idea, and the internal condyle being gone there may be a tendency to inward displacement of the remaining condyle. The knee-joint is least supported in its perfect state upon its inner side, such being the case, upon *a priori* grounds we can suspect that it is the aspect where least resistance is required, and we may hope that the joint, repaired as it is, may suffice after a time to carry him through life, if not in his former occupation as a coal-miner, in some less laborious position.

There has been some new formation at the fractured surface, but there has been no apposition of this surface to the tibia.

The patient says that when first he began to walk a few steps without his crutches, he recognised a tendency of the knee to fall inwards, but latterly he has not perceived this and though he limps considerably, yet he is able to walk fairly well.

CASE OF SPINA BIFIDA.

By E. GLOVER TENNANT, M.R.C.S.E.

On September, 2 Mrs. C. brought an infant to me, *æt.* 3 months, suffering from Spina Bifida. She informed me that the child had the tumour at birth, and that it was then about the size of a walnut, but had increased in size considerably since. On examining it, I found a tumour situated in the middle lumbar region, about as large as half a good sized orange; the skin covering it was thin, marked with reddish or violet shades, and in one spot was commencing to ulcerate. It was quite transparent, and I could not detect the presence in it of either the cord or nerves. Pressure upon the tumour did not appear to cause any uneasiness. The child was well developed and healthy, the head rather large, and the fontanelles slightly bulging; the lower limbs were in proportion to the rest of the body, but the child never moved them; both feet were turned in the direction of talipes varus, and there was no reflex motion on tickling the soles. The mother also said that there was incontinence of urine and *fæces*.

I punctured the tumour with a small trocar and canula, and drew off about three ounces of clear, pale straw-coloured fluid, quite emptying the tumour; this was followed by marked depression in the fontanelles. After the subsidence of the tumour I could distinctly feel an opening in the spine about three-quarters of an inch long and a quarter of an inch wide. I then applied a firm compress of cotton wadding and a bandage.

September 5.—The tumour has refilled, and is quite as large as before. I again tapped it, drawing off about two ounces of fluid (not emptying it altogether this time), and then injected through the canula, by means of a hypodermic syringe, half a drachm of Morton's solution.

September 6.—The child has passed a very restless night, but is now quieter; tumour same size as before, but not so transparent.

September 7.—The child has passed a good night, the tumour is decidedly smaller, and the skin covering it is thicker and slightly corrugated.

September 11.—Tumour rather larger, and the fontanelles slightly bulging. Drew off about an ounce and a half of fluid, and injected half a drachm of Morton's solution.

October 1.—Again punctured the sac, drawing off about one ounce of fluid (thicker and more yellow in colour), and injected half a drachm of Morton's solution.

October 7.—The tumour is now much smaller, and is hard round the circumference, but soft and fluctuating in the centre. I again tapped it,

drawing off about two drachms of fluid, and injected half a drachm of Morton's solution.

October 15.—Tumour much reduced in size, and still showing signs of contracting. Allowed the mother to take the child home.

November 23.—The tumour is now nearly level with the back, and consists entirely of firm condensed tissue. The fontanelles are flat; the child moves its legs freely, and has, apparently, more control over the sphincters. The feet are much better, but are still slightly turned in the direction of calcaneo varus. The child is plump and healthy, and growing well.

Forbes, N.S.W., December 5th, 1887.

A CASE OF LAND SCURVY.

By W. J. BARKAS, L.R.C.P. LOND., M.R.O.S. ENG., LATE SURGEON TO WARIALDA HOSPITAL, N.S.W.

J. B., aged 67, was admitted into the Warialda Hospital, on January 14, suffering from scurvy. It appeared that for some time before admittance he had been acting as a shepherd, and had lived solely for the last two or three weeks on tea, damper, and salt meat. At the latter end of that time, he commenced to feel great languor and weakness, became rapidly emaciated, and scurvy broke out. On admission he was in a dreadful state of debility; the skin was one mass of purple blotches from head to foot; blood poured from his nose and mouth; blood was coughed up in abundance; his motions were blood almost purely, and what he micturated was mostly blood; the gums were severely ulcerated and swollen; altogether the case was the severest one I have ever seen, though scurvy is rather frequent up in these parts. I ordered him perfect rest in bed, lime-juice frequently as a drink, any good nourishing food that he would take, an alum and myrrh wash for the mouth, and the following mixture:—

R.—T. ferri perchlor. ℥ xv.

Sp. chloroform ℥ xv.

Ext. ergot liq. ℥ x.

Aq. ad. 3ss.

to be taken every four hours. The improvement on pursuing this treatment was immediate, the bleeding from all parts gradually but rapidly diminishing in quantity, and in nine days had completely ceased; the skin also quickly approached to its natural state. I then gave as a tonic:—

R.—Acid nitr. hydrochlor. dil. ℥ xv.

Sp. chloroform ℥ xv.

Quinæ sulph. gr. j.

Aq. ad. 3ss.

three times a day. On the 29th diarrhoea, but without blood, set in and was checked by a dose or two of a mixture of acid sulph. dil. and tinct. opii. On February 2nd, the patient was discharged, better as he said than he had been for a long time. The case is remarkable for its extreme severity, the advanced age of the patient, and the rapid recovery under the treatment. I have found that in my practice, cases of scurvy recover more quickly when small doses of ergot are given, than under any other plan, and more especially so when combined with iron. As to the cause of scurvy, I am as completely in the dark as other observers appear to be, but two predisposing causes have been invariably present in all my colonial cases, viz., a diet solely of tea, salt beef, and damper, and creek or dam water, with the addition of the monotonous, solitary life of a shepherd.

Regent St., Paddington (Sydney).

A CASE OF DIABETIC COMA.

By W. H. CRAIG, M.R.C.S. ENG., L.R.C.P. LOND.

LATE in the afternoon of Saturday, July 9th, 1887, I first visited Emily C—, a single woman, aged 23, who, I was informed, had been ailing for two or three weeks. Patient was a woman of sallow complexion, looking pale and haggard, she was not confined to bed, but had done her usual cleaning and housework that afternoon. She complained of a constant sick feeling, attended with a frothy spit, also of loss of appetite, constipation, and great lassitude. Her abdomen was rather distended, giving the idea of at least four months pregnancy, her catamenia, she said, ceased suddenly five weeks previously after having been on her one day only, through getting wet, and at the next period (*i.e.* one week before my visit) she merely had a slight "show." She denied any possibility of pregnancy and the condition of her breasts supported her statement, as there were no enlarged veins to be seen ramifying over them. Her tongue was thinly coated with a whitish fur. Heart and lungs free from any adventitious sounds. Temperature normal. Patient had evidently lost a good deal of flesh. She made no complaint of great thirst at this visit, but I subsequently learnt that for five or six months at least she had been drinking enormous quantities of water, tea, &c. Otherwise she had enjoyed good health.

I was inclined to look upon the case as one of dyspepsia and prescribed a mixture of acid nit. mur. dil et tinct. nu. vom. et inf. gent. co., to be taken three times a day and two pil. aloës. et ferri o. nocte and recommended more out-door

exercise, (her occupation had been house-work, as her mother was dead and she had to take charge of the house). I asked her to come to me in about a week, and to bring some of her water for examination.

Family History.—Father living and enjoys good health. Mother died of phthisis, accelerated by alcoholism, two years previously. Several brothers and sisters living and enjoying good health.

During the following night, after having taken one dose of the mixture and two of the pills, vomiting set in attended by severe pain in the right side of the abdomen, and extending around to the right lumbar region. She vomited the pills soon after taking them. The pain and vomiting continuing, I was asked to see her again next morning, and visited her at 10 a.m. (July 10th) when I was much struck by the alarming change that had come over her; her face was expressive of great anxiety, and the features were very pinched. She was evidently suffering from severe pain which she referred to the hepatic region; the respiration was very laboured, both inspiration and expiration being noisy and difficult, but no physical sign could be detected in chest to account for it. Heart sounds clear and regular at 120. Temperature in axilla only 95.4. Tongue dry and brown, and patient was troubled with an almost unquenchable thirst, for no sooner would she take a drink of water than the tongue would again become perfectly dry, and the craving for more drink return. The vomit only consisted of yellow mucus. Feet and hands cold. On boiling some urine in a spoon found a cloudiness which did not disappear on adding a few drops of vinegar; still the pain was so severe that in spite of some albuminuria I injected gr. $\frac{1}{2}$ morph. acet. and ordered an effervescing mixture to settle the stomach.

At 1 p.m. she was free from pain and had had one or two short dozes; the vomiting had entirely ceased and the tongue was not quite so dry, although she had not had a drink for fully half an hour; thirst not so great; pupils small and inactive. Temperature still sub-normal; pulse 108-114, respiration 24 and still laboured; had nearly lost the use of her legs. Ordered a soap and water enema as bowels had not been open for two days, and this brought away some scybala.

At 5 p.m. her condition was much more unsatisfactory, she had been very drowsy all the afternoon, and was then in a semi-unconscious state, some low muttering delirium. Would answer when spoken to, but speech was so thick that it could scarcely be understood. Would sit up in bed and take a drink when asked to do so. Tongue as dry and hard as it was possible for it

to be, could still protrude it. The temperature was still sub-normal and the pulse was now extremely feeble, so that I gave a tablespoonful of brandy in water, and ordered brandy and egg mixture every quarter of an hour or 20 minutes. Some rhonchus had now appeared over bases, the respiration still of same character; urine pale and clear; of acid reaction; S.G. 1032; contained a trace of albumen and abundance of sugar. When heated with some liq. potassae and cupri. sulph., gave a copious bright yellow precipitate; heated with liq. potass. alone became dark brown. Also gave the typical sugar reaction with Oliver's Indigo-carmin test papers. Possessed a sweetish smell, and gave the "acetone reaction" with perchloride of iron.

At 7 p.m. Dr. Knaggs kindly saw her with me, when she was more comatose and would not attempt to answer questions, although she would make the faintest effort to protrude the tongue, which however, was not nearly so dry as at 5 p.m. Temperature in axilla, 96.4; pulse 120, and a little stronger than before the brandy was administered; respiration 24 and still laboured. Some râles and rhonchus heard over bases; extremities show a tendency to become cold. Pupils still small and inactive to light. Slight reflex sensibility remained on touching eyeballs. The possibility of narcotic poisoning was discussed, but no odour of any drug could be detected in the breath or in the urine. The symptoms being decidedly cerebral, we decided to blister behind the ears, and to give gr. $\frac{1}{4}$ doses of calomel every hour, and applied dry cupping glasses along the sides of the spine.

At 10 p.m. her condition was unchanged excepting that the respiration was not so loud, and fine mucous râles were now audible all over the chest. Patient never regained consciousness and passed away quietly at 6.15 the following morning, about 31 or 32 hours after the onset of urgent symptoms. The pupils dilated after death, and the distension of the abdomen disappeared, so that it was clearly not due to uterine enlargement.

My excuse for bringing this case under the notice of the profession is its comparative rarity, and it is only within the last few years that it has been fully described. Dr. Dreschfeld, in a paper read before the Manchester Medical Society in 1881, analysed more than 50 cases and showed that they might be divided into three groups.

See *Brit. Med. Journ.* 1881, II., p. 710, also Sir Wm. Roberts' work on Urinary and Renal Diseases, 4th edition, p. 271. It will be seen that the symptoms in the preceding case were almost identical with those of the first group.

William-street, Sydney.

PROCEEDINGS OF SOCIETIES.

MEDICAL SOCIETY OF QUEENSLAND.

The first Annual Meeting of the Society was held on December 13, at 8.30 p.m., in the School of Arts. Present: Drs. Bancroft (President), Mullen, Ch. Kebbell, Hill, Gibson, Thomson, Tilston, Campbell, W. L. Byrne, Shout, E. H. Byrne, Clowes, Owens, Taylor, and Love (Secretary). Dr. Cunningham, of Sandgate, was present as visitor. The minutes of last meeting were read and confirmed. Correspondence—Two letters were read from Mr. M. C. Blandford, local correspondent of the *Australian Journal of Pharmacy*, asking permission to be present at the meetings of the Society in the capacity of reporter for that journal. After discussion, the Secretary was directed to send a courteous reply to Mr. Blandford informing him that the by-laws of the Society prevented his proposal being acceded to.

The following gentlemen were then elected members of the Society—F. Glynn Connolly, South Brisbane. Samuel Hammond, Toowoong. The following were nominated for membership—W. Kebbell, M.R.C.S., L.R.C.P., South Brisbane, T. P. Lucas, L.R.C.P.E., M.R.C.S., L.S.A., Brisbane. The Secretary then read his report for the year 1886-7.

SECRETARY'S REPORT.

Mr. President and Gentlemen,

It is with great pleasure that I present this, the first Annual Report of a Queensland Medical Society to you to-night. Such a Society has evidently been a long-felt want among those engaged in the practice of medicine in this Colony. This want has taken practical means to be remedied on three separate and distinct occasions. In the earlier days, as long ago as 1871—sixteen years ago—the movement was inaugurated, and a Society was constituted consisting of eleven members. Unfortunately this attempt at co-operation was short-lived, as, after a career of nine months, it expired. The cause of its decease seems to have been an attempt on the part of one of its members to open up a discussion of a public nature on the relations existing between the members of the medical profession and chemists, with reference to prescribing and dispensing. The feeling then slumbered for eleven years when it again made an attempt, and this time with a little more success than before. Nineteen names were enrolled, but the interest must have been very half-hearted, as the chronicles tell us that though one member was enrolled in addition to the nineteen already referred to, only eight out of the twenty paid their subscription to the Society. After a chequered career, lasting from May 1882, to March 1883, during which time the Society held fourteen meetings, it seems to have followed the fate of its predecessor, partly owing to the disunion produced by questions of ethics, partly owing to the absence of the discussion of professional subjects, and partly to the departure of the Secretary for England.

Then came a nap of three and a-half years, during which time the numbers of the profession in the metropolis, and its more immediate neighbourhood, had increased considerably, till, in October of last year, a third (and let us hope a permanently successful) attempt was made to bring the members of the profession more into touch with one another. Fifteen months have elapsed since then, and the Society now bids fair to have a useful and permanent future before it. Several factors are working together to bring about

this much-to-be-desired result, viz.:—the increased number of our profession in this city and colony generally—there being at present 65 practitioners resident within a radius of 50 miles of Brisbane, 43 of these being men in active practice in Brisbane itself. Another and a vital factor towards the present successful status of the Society is that its functions have been exercised in a right direction, questions of legislation and of ethics in general have been carefully eschewed, and attention has been given entirely to a subject which lies altogether within the scope of medicine, viz.:—the study of disease. In none of the minutes of the former Societies can I find any mention whatever of any clinical, pathological, or physiological subject having been brought under the notice of members for discussion: but their time seems to have been taken up with discussions of bye-laws, earnest and profound deliberations as to whether they should attach themselves to the British Medical Society, to the local Philosophical or Royal Society, Pharmacy Bills with deputations to Parliament, questions of Hospital Management, and so forth. Hitherto, following wise councils, the present Society has confined itself solely to the every-day work of the profession, judiciously waiting till its cohesion and importance shall give its decision full weight in matters ethical and legislative.

Happily we have still among us members of the defunct Societies, and by their past experience these men have shewn us how to steer between Scylla and Charybdis.

At the present time our membership is 43, and at last meeting two candidates were nominated, and to-night two more names will be submitted for your approval. This is a large percentage of the medical residents in the district, and shows a healthful friendliness and desire for mutual intercourse and mutual improvement. Of our 43 members only one has not paid his subscription, and this I take to be rather from inadvertence than from any lack of interest in the Society and its work; and one member was only elected at last meeting. The Society has held 16 general meetings and 16 council meetings during the 15 months of its existence. The average attendance at the council meetings has been four, and at the general meetings 13. Papers have been contributed in the following order:—

On Pernicious Anæmia, by Dr. Love; on Blood Formation, by Dr. Gibson; on a case of Obstruction of Bowel, by Dr. W. S. Byrne; on Typhoid Fever, by Dr. Hare; on Diphtheria, by Dr. Love; on Supra-pubic Lithotomy, by Dr. Gibson; on Paraldehyde, by Dr. Hogg; on Chronic Alcoholism, by Dr. Little; on Digestive Ferments, by Dr. Gibson; on Conditions Favourable to Diphtheria, by Dr. Taylor; on Five cases of Laparotomy, by Dr. Ryan; on the Naso-oesophageal tube in Forcible Feeding, by Dr. Hogg.

One special general meeting was held on July 27 to hear a paper from Dr. Gibson, on the Digestive ferments, illustrated by some excellent specimens, prepared by Mr. Shepperson, travelling agent of Burroughs, Welcome & Co., and on October 27, seventeen members met together at the first annual dinner of the Society. Outside the ordinary work of the Society, the only subject which has engaged its attention has been the question of a local University, the views of the Society being embodied in a requisition to Parliament, favouring the project, with certain special modifications. Interesting cases and specimens have been shown from time to time by members and, through the kindness of Messrs. Elliott Bros., instruments and new drugs have been exhibited to the meetings.

The first Intercolonial Medical Congress has been held since our foundation, and it was hoped that our

President would have represented us, but circumstances ordered it otherwise. One of our number, Dr. Rendle, did go, but his intention was not known till too late to invest him with representative powers.

As concerns the officers of the Society for the past year, they have worked well and harmoniously, and here let me express my thanks, as Secretary, to my predecessor, Dr. Rendle, who collected information from all quarters and did much to establish the Society by his exact and admirable work. In January of the present year Dr. Rendle handed over his work to me, with comparatively little left to do, but to carry on the work he had so well begun.

Dr. Bancroft, our President, has given us valuable assistance in the chair, and we all regret that indisposition has lately prevented him from giving us his co-operation, as before.

One word as to our finances, and I have done. The subscriptions to the Society for the past year have amounted to 41 guineas. To this must be added a balance of £2 0s. 10d., a surplus from the 1882 Society, and £12 2s. 3d., from the 1871 Society. This latter sum, £12 2s. 3d., was handed over on condition that it should be spent on books, to form the nucleus of a library. Of this sum 30s. has been expended in the purchase of an anatomical atlas, and £8 8s. has been voted for a copy of "Ashhurst's Surgery," which has not yet, however, been procured for the Society, owing to the want of accommodation. Thus the total income of the Society has been £57 4s. 1d., and the total expenditure £35 9s. 10d., leaving a balance of £21 14s. 3d., in favour of the Society. The expenses of initiation, procuring copying apparatus, letterpress stationery and plant generally, have been necessarily heavier than they will be in the coming year, and at the end of that time there will be a considerable sum capable of appropriation for many useful objects. Dr. Owens has given his services as an auditor. Some donations which have been made towards starting a museum, I have to acknowledge on behalf of the Curator, viz., Pathological specimens of a typhoid bowel, showing perforation, and a fallopian gestation, both from Dr. Hare, and some copies of the *Australasian Medical Journal* from Dr. Owens.

The proceedings of the Society have from time to time been published in the *Australasian Medical Gazette*, which the Society has recognised as its accredited organ, and lately an arrangement has been come to by which all members subscribing to that journal do so through the Society, which benefits the Society to the extent of 10 per cent. discount allowed to us by the publisher. Our meetings have hitherto been held in the School of Arts, where the committee have provided us a room at the rate of 10s. 6d. per night, and our council meetings have been held at Dr. Rendle's, and afterwards at Dr. Bancroft's private residence. In conclusion I have to thank the members for the good-will and hearty co-operation which they have given me as their secretary, and I can only urge them to go on in the work which has been so auspiciously begun, and to make the Medical Society of Queensland an institution for promoting good-feeling between the members of the profession, and of furthering the cause of the noble profession of which they are the exponents.

WILTON LOVE, Hon. Secretary.

Dr. Thomson replied, and in thanking the Secretary for his report said, that as a member of the 1882 Society, he thought that Dr. Love's remarks about that Society were somewhat ill-deserved, as at that time concerted movement on the part of the medical men was necessary to prevent the passing of the Pharmacy Bill, which was framed by the chemists entirely to their own interest.

He recognised with pleasure the progress of the Society, which had been greater than was anticipated, and much of it he thought had been due to the energy of the Secretary.

The officers for the past year then retired, and a ballot was taken for their successors with the following results:—

President, Dr. Joseph Little; Vice-president, Dr. John Thomson; Secretary and Treasurer, Dr. Wilton Love; Librarian and Curator of Museum, Dr. Tilston; Council, Drs. Bancroft, W. J. Byrne, and Gibson; Auditors, Drs. Owens and Clowes.

The retiring President, Dr. Bancroft, then read the following

PRESIDENTIAL ADDRESS.

Gentlemen,

I have to apologise for my absence from several of the meetings of the Society in consequence of poor health, and from the annual dinner, which passed off so satisfactorily. I feared for some time I should not be able to attend this, the annual meeting; however, I am gaining somewhat in strength, and you will pardon me if my address does not come up to the desired standard. I also regret being unable to attend the Australian Medical Congress, at Adelaide, so ably presided over by Dr. Verco—the most notable of all Australian medical gatherings. But Dr. Rendle, who attended as our representative, will inform us as to the proceedings and the published report of the papers read, which may be shortly expected to be in our hands. I have often promised our Honorary Secretary a contribution on the present aspect of *Filaria* disease, and though long delayed, there is hope that I shall soon be able to submit to you my later observations.

For years it has been the opinion of many of us that a Medical Society should be established in Brisbane. Seventeen years ago such a Society was formed, when I was appointed Honorary Secretary. Several meetings took place, but no agreement could be come to about certain usages, and so, in attempting this rectification, the Society ceased to exist. The balance of the subscriptions remained in the hands of the Treasurer, Dr. Bell, which, together with bank interest on the same has now been paid over to our Librarian. Years later, Dr. Patrick Smith essayed to get the profession to combine, but the evil genius that presides over ethics again interfered, and after a number of meetings in the library of the Museum that Society broke up. Profiting by experience when the present Society was formed, it was decided that no consideration should be paid to ethics for a time, and that the efforts of the members should be entirely devoted to medical and surgical learning. In this way, happily, we have arrived at the end of our first year without disagreement. To Drs. Taylor and Rendle is due the credit of having launched the Society into existence. Dr. Rendle, as the Honorary Secretary for the first part of the term, has given us rules and regulations by which, if we work wisely, the Society may be guided to a prosperous future.

There is abundance of work for our new Association in the study of the phenomena of health and disease in this colony, so recently invaded by the civilised man, and in bringing our observations to a focus at the meetings we may hope to obtain assistance in clearing up the obscurities that beset our biological studies—the most difficult of all scientific enquiries.

In this almost tropical region, and in the hotter parts further north, and in the interminable western plains, all phenomena of life, of chemistry, and of botany, differ more or less from those with which we were

familiar in our student home. Our animal food is much the same, but undergoes rapid changes. The vegetable is more divers, and will become more and more varied as the cultivation of tropical plants extends. The weather is of another order. We stand in the latitude sailors call "the variables." At the present time we should be experiencing summer days, but we find the air very cool. We have no frozen up winter season. Sheep and cattle can lie out of doors all through our coldest month. The winter coughs of England, so remarkable in all large assemblies of people, are here absent. Phthisis is not a common disease, and if people with delicate lungs did not come seeking health to these shores, there would be few cases of the kind to treat. In the dry and dusty weather of early summer we have, on two or three occasions, seen an epidemic of pneumonia, not confined to town, but spreading over a large extent of the colony. To what the cause of this may be due is a subject for your consideration. It was not due to street dust, as it happened as well in the grassy, unbroken country. On one occasion the epidemic extended from Cape Moreton to Roma within a few days. Now that we have such an excellent meteorological observer as Mr. Wragge, we may hope for assistance from his department. Asthma is a common disease as well of children as of adults. Asthmatics from Europe are often cured by coming here: our asthmatics recover by travelling elsewhere. To what is the asthma of children due? Here is an interesting study for our young observers.

Sun strokes, once so common, demand attention. They happened mostly at the wharves. The steam hoist may have helped us to some extent by reducing the severe labour of unloading vessels, but sun strokes will happen again and again in moist, warm weather, and the medical man will act wisely by advising his patients as to exercise and stimulants at such times. The summer in the coast country is often enjoyable were it not for the hot, moist days in which the plants luxuriate. Then muscular debility becomes noticeable.

A visit to the mountainous country of Toowoomba and Warwick has a marvellous effect in restoring the energy, though the direct sun heat of those parts is, if anything, greater than we experience on the coast.

The sick man cannot enjoy the summer sunshine of any part of Queensland, but the nights on the higher tablelands are cool and refreshing. All the native animals are nocturnal in their habits, and a mid-day rest in summer would be a good rule of life.

The bush-workman, who does contract jobs, invariably takes his siesta; but the day-labourer in town only knocks off when the day is exceptionally hot.

Some regulations with regard to the working day of summer seem called for; but the attractions of the public house to the thirsty workman are so great as to deter employers from instituting the necessary rest time.

Were it not that we have such a large influx of people from Europe, the native born would be guided by their own experiences and sensations, and rules of life would soon become established; but it is vain for the doctor to talk to British to change their habits, or to Germans to give up lying under their feather beds, even though the thermometer may be standing at over 80° in the shade.

There is more hope of children adopting good rules of living, and much more could be done in our free schools than is attempted in teaching laws of health. The school buildings would need to be constructed with more regard to the exigencies of the climate. The water supply of schools is still very defective, and little care is taken in distributing infectious diseases. School children could be taught all the fundamental rules of

sanitation, the essence of which is cleanliness with regard to everything.

That this country will sustain an enormous population by wise culture of farm and grazing area, there cannot be the slightest doubt. What supported a few thousands of wild aborigines will give sustenance to many millions of civilised people, and the dreadful apprehensions created by the Malthusian doctrine need not be mentioned here for hundreds of years. In a country where a crop of wheat and a crop of maize can be raised to perfection in less than twelve months from the same land, food must become abundant, and with proper methods of storage of grain and other food stuffs, the harvests of years of plenty will bridge over the years of drought which from time to time will recur. The opinion of medical men as to the construction of houses and workshops suitable to the climate will need to be taken. We purchase and initiate everything British; we put little iron ventilators, a handbreadth in size into our walls; we box everything in obedience to the necessities of a rigorous climate, where no such climate exists. Again, we set at defiance all rules, and make our homes of single layers of sheet iron, because the material is cheap, the temperature of which in sunshine, at times rises to 150 deg. Far. and over, and we expect women and delicate children to live inside such structures.

That this may be good practice in weeding out of existence a delicate race, unsuited to tropical lands, may be contended. In the city of Brisbane, where the houses are better built, the death-rate is low, but in the suburbs, where the iron roof, often unceiled with wood, is in close proximity to the heads of the residents, the death-rate is out of all proportion to what should happen, and I believe accounts partly for the excessive infantile mortality in summer. Few properly constructed ventilating contrivances are to be found in our rooms, and if a ventilator of fretwork tracery is put in anywhere, there is no means made of closing it to exclude the cold, westerly wind. The arrangements used in the railway carriages, made on a large scale, might wisely be applied to our better houses. With regard to water supply, so essential to our well-being, much yet remains to be done in the application of sanitary knowledge. In the chief city of this colony most impure and filthy water is supplied to us every summer, and if we are not poisoned thereby we are often disgusted at the odours. This Society should make an early effort to rectify the defect, and no more important necessity can engage our attention. If the city is to go on increasing at its present rate, and if it is ever to be a desirable place to live in, abundance of pure water should be obtained, no matter what the expense may be.

Concerning the subject of ethics, the consideration of which has for so long prevented the medical practitioners from uniting, I would advise that for the coming year a sub-committee of the wisest and most experienced of us should sit on the problems, making all needful investigations, and bring up such a code of rules as may be found to suit us.

In thus slowly building the Society, all new conditions and difficulties of town and country practice may be noted and provided for, so that the future working of the profession may be for the good of the colony, that we may stand high in the estimation of the people, as honest advisers in sickness and in health, and may be faithful to the sacred trusts imposed on us.

Dr. Gibson proposed, and Dr. Owens seconded, a hearty vote of thanks to Dr. Bancroft for his address and for his valuable assistance in the chair during the past year. Carried unanimously.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE 69th General Meeting of the New South Wales Branch of the B.M.A. was held in the Royal Society's Room on Friday, 2nd December.

Present:—The Hon. Dr. Creed, M.L.C. (President), in the chair; Drs. Clubbe, Sydney Jones, McCormick, Brady, Chambers, Hankins, Scot-Skirving, Fiaschi, Coutie, McCulloch, Worrall and Crago.

The minutes of the previous meeting were read and confirmed.

THE PRESIDENT stated that the first business on the paper was the consideration of the amended by-laws, but as DR. CLUBBE had a patient present, perhaps it would be as well to take his paper first.

DR. CLUBBE then read some notes on a case of Fracture of the Acetabulum.

A discussion ensued, in which DRs. SYDNEY JONES, BRADY, and MCCORMICK took part. DR. CLUBBE replied.

The by-laws were then considered and discussed and, after some slight alterations were made, they were passed.

DR. MCCORMICK, of Macquarie-street, read a paper on Digestive Ferments.

Some very interesting demonstrations were made, illustrating the action of certain ferments.

REVIEW.

AMBULANCE HAND-BOOK: ACCIDENTS AND THEIR TREATMENT, AIDS IN CASES OF INJURIES, SUDDEN ILLNESS, &c. COPIOUSLY ILLUSTRATED. ENLARGED EDITION. COMPILED BY G. P. M. WOODWARD, M.D., F.R.C.S.I., AND ISSUED BY THE COMMISSIONER FOR RAILWAYS, SYDNEY, 1887.

THIS is a handy little book of 184 pages, illustrated by not less than 75 woodcuts, specially compiled, by request of the Commissioner for Railways, for the Railway Ambulance Corps in New South Wales by Dr. Woodward, a member of the N.S.W. Railway Medical Board. It contains an immense amount of information for non-professionals, instructing them in the "putting up" broken limbs so as to prevent further injury before surgical aid can be procured, moving injured or sick people, improvising tourniquets, splints, pads, stretchers, stretcher drill, reviving the apparently drowned, first treatment of burns, scalds, &c., &c. It should prove useful, not only as a reference-book of immediate aid to the injured, but also as a guide to those intending to give lectures on the subject, as well as to members of branches of St. John's Ambulance Society. The book is neatly bound in red leather, and published at the low price of 2s.

[Copies of this Ambulance Hand-book can be obtained only through L. BRUCK, of 35 Castlereagh Street, Sydney; price 2s., or 2s. 3d., postage paid.]

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

AUSTRALASIAN
MEDICAL GAZETTE.

SYDNEY, JANUARY 15, 1888.

EDITORIALS.

SMALL-POX AND QUARANTINE.

THE Engineering Inspector under the Public Health Act of Tasmania has prepared for the Chief Secretary (and, it may be assumed, by his direction) a Memorandum on Quarantine. Copies of this document have been widely distributed, and expressions of opinion upon it are invited. The objects of the Memorandum are two; to show that the system of defence against sea-borne disease employed in Australasia is useless, and to invite reconsideration of it with a view to the adoption of medical inspection. These objects it is attempted to forward by quotations which show that under certain circumstances English and Indian sanitarians recommend medical inspection and condemn quarantine; by asserting that the Australasian Sanitary Conference of Sydney, 1884, advocated quarantine (and, by implication, that it condemned medical inspection); and by the remark that the exclusively medical constitution of that Conference caused this branch of the science of disease-prevention to be considered on medical and etiological grounds, which are said to be "theoretical." They are presently contrasted with what are called "practical" grounds, for which it is proposed to secure regard at any future Con-

ference that may be held by composing it "in part, at least, of practical business men."

We do not intend to criticise this communication at length. The respective uses of quarantine and medical inspection have been discussed in these columns sufficiently often of late to render it unnecessary to reopen the subject; and the evil conjunction of stars—or of Ministers—by which an Inspector of Engineering is compelled to assume the rôle of proficient in one of the more recondite branches of State Medicine fortunately has no influence to oblige other people to join issue with him. There are, however, certain misstatements in it which should not pass unnoticed, and these we now point out. The Resolutions of the Sanitary Conference are roundly condemned in this Memorandum because, to put it briefly, they are believed to advocate the use of quarantine at all times and in all places as an all-sufficient defence against epidemic disease. But there is no foundation in fact for this view. It is stated clearly enough in the Preface to the Transactions that the Delegates deliberated under the influence of three principles mainly. These are, first, that the only true defence of nations against epidemic disease consists in measures of internal sanitation—that is to say, in the measures necessary to secure pure air, pure water, sound food, and vaccination; secondly, that the ease of communication between the several Territories which constitute Australasia renders it necessary to regard them as one country *quod* infectious disease, and that therefore quarantine as between adjacent parts must be condemned and relinquished; thirdly, that community of circumstances binds together the several Territories in respect of contagion imported from the outside world, and that consequently a plan should be agreed upon by which uniform practice of the kind of quarantine deemed likely to be useful against it might be secured. In the second place, the protest which this Memorandum embodies is addressed equally to New South Wales and to other Territories. The occasion of remonstrance is easy to detect. During the recent outbreak of small-pox at Launceston, Victoria and South Australia instituted against Tasmania a quarantine which was marked by all the futile rigour of the middle ages. Her Government now complains of this treatment as being useless against disease and disastrous to trade; and in our opinion it has every reason to do so. But what are the facts in the face of which New South Wales is indiscriminately included in this general complaint? They are that, while her Government, penetrated as it is with a sense of the soundness of the principles just recapitulated, has ever tried to adhere to the resolutions of the Conference,

even on this occasion it did not depart from them. Notwithstanding the neglect of vaccination by its people, and the greater risk they therefore ran as compared with the people of South Australia and Victoria, it exercised against Tasmania, as being an adjoining Territory, only that very medical inspection which is so ardently advocated in the Memorandum.

It is thus by a very curious oversight that the Government of Tasmania has neglected to avail itself of some not unimportant support to its present contention which is at its command. It appears, indeed, to be singularly oblivious of the course of affairs abroad, even when they most nearly touch the interests of its people. It seems, therefore, not improper to point out in so many words that while the quarantine between adjacent Territories which it so justly deprecates was imposed by Boards "composed, in part at least, of practical business men," the medical inspection it desires actually was accorded by a Health Officer whose opinions agree with those expressed by a purely medical Conference. But perhaps we understand by the phrase "practical business man" something other than is intended by the Government of Tasmania. We therefore conclude by explaining that we take it to signify one who looks to his weapons before joining the fray.

We regret to hear that Dr. James Boyd, of Sandhurst (Vic.), has laid himself open to adverse criticism by accepting from James Tonkin, of Echuca, a payment of £1 in return for the issue by him, as one of the medical officers of the Bendigo Hospital, of a ticket of admission to that institution to this sick man. We are of opinion that, if the circumstances are as reported, he has been guilty of conduct unworthy of a medical practitioner, for if the applicant was in a position to make any payment for admission it should have been made to the institution and not to the person recommending it. Such an act, we are sure, is but rarely committed by one of our brethren, and we can but hope that in the few and rare cases which do occur, exposure may follow as in this one. We make the above comment, in the supposition that the payment was made for the recommendation, and was not a fee paid for a consultation resulting in the very often eminently useful advice to seek treatment in a hospital.

DR. E. C. STIRLING'S ADDRESS, AT
THE ADELAIDE UNIVERSITY, ON THE
AIMS AND METHODS OF BIOLOGICAL
SCIENCES.

DR. STIRLING'S thoughtful, scholarly, and indeed masterly address at the Commemoration of the University of Adelaide deserves a far wider circle of hearers than those who had the pleasure of listening to it. The eloquent and able advocate of the attractive and useful sides of Biological Science has no need to apologise for the want of the arts and refinement of a cultured style. Dr. Stirling's address throughout is marked by conspicuous superiority, and is alike worthy of his noble *Alma Mater* and of the holy cause of Science which he has so devotedly and faithfully championed in the chief seat of learning in the metropolis of his adopted country. It is not without feelings of shame at this "Centennial," when we are holding up to the gaze of admiring nations our unprecedented history of developmental success, that in Science, alas! there are no trophies. But it is not without encouragement for the future, now that the trials incidental to the formation of new lands are over, that we not only have Science holding her proper place in the Universities, but that we have exponents of the natural sciences who, having given us a taste of their quality as in this lucid and elaborate exposition are able and willing to help on the young aspirants to scientific honours to the goal of their ambition. In former years it was to the few and far between, who were privileged to sit at the feet of Gamaliels in the older world, that Science unfolded her ample page. But "*Non Contingit cuivis homini adire Corinthum*." Now we have fully equipped medical and scientific schools in the Universities of Sydney, Melbourne and Adelaide. If the last be the youngest daughter, she certainly gives golden promise of excelling them all. Amongst the reasons for the study of science Dr. Stirling says:—"It is a claim of Science, and I think a strong one, that it seeks not to

carry conviction to the mind by any *obiter dictum* of authority, but expressly suggests, by its fundamental methods of observations and experiment in the great realms of nature, 'an ultimate Court of Appeal' to which all may apply with the certainty that, in things knowable, a verdict uninfluenced by any bias, prejudice, or tradition, will be given to him who understands those methods, and rightly applies them." One outcome at least of such an appeal is a practical acquaintance with the value of evidence that can scarcely be reached in any other way. "The surest and best foundation for that complex superstructure we call a liberal education is science, in virtue, both of its methods and of its facts. The facts, perchance like other facts, may be forgotten, but the spirit of philosophic enquiry, wholesome scepticism, and veritable craving after accuracy remain ever as a lasting possession, and as applicable to any walk in life as they are to the science of which these faculties were begetters."

In praise of Human Physiology, Huxley says, "It is in itself an education broader and more comprehensive than much that passes under that name. There is no side of the intellect which it does not call into play, no region of knowledge into which either its roots or its branches do not extend. Like the Atlantic, between the old and the new world, its waves wash the shores of the two worlds of matter and mind. Its tributary streams flow from both; through its waters, as yet unfurrowed by the keel of any Columbus, lies the road, if such there be, from the one to the other; far away from that north-west passage of mere speculation, in which so many brave souls have been helplessly frozen up."

We count the students of the University of Adelaide happy in having so able and devoted a teacher as Dr. Stirling. It is men of a like calibre that we require to rouse enthusiasm and persevering interest in our students. Contests in the wider arenas of the older countries have proved that our youths have the qualities which, if not throttled in the flower of their adolescence by the too engrossing interest in gain, would yield noble fruits to our national granary of Australian Science.

THE USE OF MORPHIA BY HOMŒOPATHS.

A case of some interest recently occurred in Auckland (N.Z.). It seems that a Mrs. Cole, who died on Saturday, November 26th, first consulted, on the Wednesday previous, a Dr. Murray Moore, who practises as a homœopathic practitioner in that city. He found her to be suffering from a severe attack of dysentery, and according to his statement published in the *New Zealand Herald*, of November 29th, he administered to her on that day the homœopathic preparations: "Mercurius Corrosivus 3x and Colocynth 3x;" on Thursday, he changed these to Veratrum and Ipecac., to be taken alternately; these on Friday, being altered to Arsenicum and Veratrum given in the same way. As was to be expected, the relief to the patient from these "remedies" was nil. Having persevered in this way until 9.40 p.m., on Friday evening, he goes on to say that he "informed the nurse that the patient was in a very serious condition, but that he still hoped to be able to give her some relief," and "all ordinary means of homœopathic treatment," having failed, he considered it his duty, as he had not with him "any solution of opium or morphia suitable for giving by the mouth," to inject subcutaneously over the left iliac fossa five minims of the dilute "injectio morphinæ," which, according to Dr. Girdler, the consultant in the case, was that of the *British Pharmacopœia*, and would, therefore, contain half a grain of acetate of morphia, though at the same time this practitioner makes the strange statement that it was "about one-sixth of a grain." Both practitioners are somewhat disingenuous with regard to this injection, speaking as they do of the "dilute" injection, though there is no such thing in the *British Pharmacopœia*, according to which it was stated to have been prepared. The only injectio morphinæ being that on page 286, of *Squire's Companion B.P.*, which contains one grain

of acetate of morphia in ten minims. We do not wish it to be supposed that we blame the homœopath for administering this dose, though undoubtedly a much larger one than is generally used by an allopathic practitioner, for the case was evidently very serious, and urgently required active treatment. What we think most to be regretted is the loss of valuable time, which took place whilst the several trials were made in genuine homœopathic style of the various infinitesimal and impotent remedies trusted to, when the case was probably amenable to rational treatment. In view of Dr. Moore's statement in a letter written in defence of homœopathy, published in this journal in September, 1884 "that the homœopath gives large doses of very active medicines the moment there is any real need of treatment, is utterly opposed to truth," we think his administration of five minims of the injectio morphinæ, of the *British Pharmacopœia*, a trifle contradictory, especially as in the same letter he says: "With the exception of malignant organic disease, the third stage of phthisis, and a very few cases of obstinate constipation, I use none but homœopathic remedies, carefully chosen." That his use of the hypodermic injection of morphia was no unusual thing with him, is shewn by the fact of his having the syringe and solution in his pocket, which certainly would not have been the case if he were not in the habit of using it. The use, by homœopaths, of what allopaths consider large hypodermic doses of morphia is no uncommon thing, for cases of death following them are not infrequent; one came to light in Sydney a short time since, where a homœopath gave a dose of half a grain in this way, the patient's death ensuing.

THE UNIVERSITY OF MELBOURNE.

SCANDALS of various kinds and degrees relating to the management of this University are so frequently promulgated that we fear its usefulness will soon be greatly lessened. Carelessness, if not worse, on the part of the governing bodies is very evident, and it is high time that a thorough reform should be instituted. The Registrar, who apparently exercises considerable influence over the Council, is an individual possessing unique characteristics, and as the following portion of the report of the Council Meeting held on December 12th, not only illustrates his personal peculiarities

but throws a dim light on the University management of examinations, we append it :—

"The CHANCELLOR said that the council would now hear the registrar in reference to the charges of blundering in the office—charges which he did not hesitate to say were without foundation.

"The REGISTRAR said the charges which the Chancellor referred to were made in *The Argus* and the *Daily Telegraph*. They arose out of the business into which the council had just been inquiring. The *Telegraph* said, among other things, that a candidate had been posted as passed in a subject for which he had actually sent in no paper. This was not the fact.

"Dr. MADDEN.—That was true of a former examination.

"The REGISTRAR.—They had got hold of the wrong end of the stick in this instance. A professor had sent in a return of a candidate as passing who had not given him papers, but that was not posted.

"In answer to questions,

"The REGISTRAR said that the professor was Dr. Hearn. No explanation was offered. Another instance given by the newspaper he referred to was that a student who was declared to have passed was at the last moment, and when he had donned his gown to go up to take his degree at the recent conferring, informed that the pass was discovered to be a blunder. That statement was an absolute lie. The fact was that the returns in medicine came in late, and this student was premature in supposing he had passed.

"Dr. FETHERSTON.—Returns should not be coming in just at the time that the degrees are to be conferred.

"Mr. ELLERY.—It seems absurd.

"The REGISTRAR.—Two years ago he had written to the council to urge that the time allowed was too short, or that if it was not too short that the examiners did not do their work properly—one of the two things. It was not possible to do the work satisfactorily in the time allowed, but in this instance there was delay on account of the practical examination in surgery. Nobody could be got except at the last moment. The examination was not started till about 12 o'clock on the Saturday degrees were conferred.

"Dr. FETHERSTON.—The greatest disgrace that has ever happened in connection with our medical school examinations! Twenty-three men galloped through the examination in operative surgery in an hour and 45 minutes. They could not have selected the instruments for the operation.

"The CHANCELLOR.—It was officially told me that the examination was properly conducted.

"Dr. FETHERSTON.—It could not be done in the time.

"The REGISTRAR, after referring to another statement which he said was altogether new to him, complained that general statements about office blundering were most unfair. Not a single case of office blundering was specified. Considering the smallness of his staff, he thought they got through the examination work extremely well."

The REGISTRAR's self-conscious virtue is sublime when considered in relation to his correspondence with the late Dr. Cortis, of Carcoar, in reference to a certain A. H. Florance, published in our issue of October, 1885. We also add further correspondence relative to the conduct of the recent examination in operative surgery, read at the Council Meeting held on December 19th together with the discussion.

The Faculty of Medicine wrote as follows :—

"The Chancellor and members of the council.

"Gentlemen.—The Faculty of Medicine begs to draw the attention of the council to the published report of the discussion in the council on the 12th inst., concerning the recent examination in operative surgery. Dr. Fetherston is reported by *The Argus* to have referred to this examination in the following terms :—

"The greatest disgrace that has ever happened in connection with our Medical School examinations. Twenty-three men galloped through the examination in operative surgery in an hour and 45 minutes. They could not have selected the instruments for the operation."

"The faculty reports that the examination was held at the last moment, because till then no subject was available on which operations could be performed; that the students had already been examined in surgery by written papers, by special examination in practical surgery at the hospital, and by oral interrogations; that the examination in operative surgery does not necessarily occupy a long time; that the faculty requested the council to adjourn for a fortnight, not because the examination itself would be of long duration, but in order to make certain that a subject would be available; and that the faculty is convinced that the examination was efficiently conducted.

"The faculty therefore begs to record its protest against the hasty utterances at the council-table, and the grave accusations against members of the teaching and examining staffs, especially when accusations are not at once followed by motion for full inquiry. In the opinion of the faculty, Dr. Fetherston's remarks were extremely unfair to the officers whose work was disparaged, harmful to the University, and calculated to give a false impression concerning the style in which examinations are conducted in the Medical School.—I have the honor, &c.,

H. B. ALLEN,
Dean of the Faculty."

"Dr. MADDEN.—There is one little mathematical fact which still remains. Twenty-three students were examined in operative surgery in 105 minutes, which gives each student less than 4½ minutes to complete his operation in.

"The CHANCELLOR said that this was not the fact, because four students were able to operate on the same body at the same time.

"Dr. MADDEN.—In any case, it was the smartest thing on record.

"Dr. FETHERSTON.—I think the faculty's letter precludes the necessity of an inquiry. Notwithstanding that letter, I am still of the same opinion that the thing was a perfect farce. Men were telephoned for to the colleges and hospitals after 12 o'clock. They were back at 2 o'clock, having gone through their so-called examination, and they got their degrees at 3.

"Mr. ELLERY moved—'That the committee already appointed re clinical instruction be requested to inquire into the late examination in operative surgery, and into the circumstances which delayed this examination until the last moment.'"

THE FIRST MEDICAL GRADUATES EDUCATED AT THE SYDNEY UNIVERSITY.

THE passing of the final professional examination for the degree of M.B. at the University of Sydney by the first class of students who have gone through their professional education at this medical school is an event of some importance in the history of the colony. The successful candidates, six in number, viz., Messrs. Armstrong, B.A., Bancroft, Davidson, Henry, Perkins, M.A., Rutledge, M.A., we sincerely congratulate on their success, and hope that all the hopeful visions which doubtless filled their minds on the announcement of the result of their examination will be fully realized. They have entered on a profession, however, in which year by year there is greater competition, and we fear that if they cherish hopes of great pecuniary reward they had better have chosen some other calling. They will, however, if they earnestly strive to do their duty, have the intense satisfaction of feeling that they are units in a noble profession, which has always been justly credited with the greatest unselfishness, and will feel that their work is of a character calculated to relieve human suffering, and to ennoble mankind. They will feel that having entered on their career, after having gone through years of close study, that they are doing so honestly and capably, and that they may fairly claim a superiority in manly rectitude to the numerous charlatans who have been so thoroughly exposed by the labours of the late Select Committee. These men, it is evident, have had no other idea than to obtain money with the least possible labour from the credulous gulls who employ men who, by their own showing, adopt a calling for which they have neither the fitness of conscientiousness or training.

EXTERMINATION OF RABBITS.

In a letter to the *The Argus*, of November 2, an amusing exhibition of assertive ignorance is made by a person signing himself J. B. Jackson, Ph. Dr., F.R.S., Graduate Berlin University. We venture to doubt that he is a fellow of the Royal Society, London, and without he is he has no right to assume the exalted title F.R.S. No person speaking of the parasitic disease (*sarcoptes cuniculi*) affecting the rabbit would, if he really possessed the learning which would justify his election to the Royal Society, make such a statement as the following, which we extract from his letter:—

"The poison of all contagious disease circulates through the blood, so taking the instance of a single rabbit suffering from the so-called 'rabbit scab,' this rabbit if worried by a sheepdog would convey the disease to the dog, and the first sheep nipped by the dog would suffer likewise, and soon the disease would contaminate the whole flock."

LETTER TO THE EDITOR.

A QUERY.

(To the Editor of the *A. M. Gazette*.)

SIR,—Would you kindly answer, through your columns, the following question:—A medical man A is engaged by a patient B to attend her in her confinement, however, instead of calling in A, she sends for another medical man C. Can A recover his fee from B's husband? The engagement, of course, having been made with his consent.

Yours, &c.,

SUBSCRIBER.

[That B is under a moral obligation to pay A the fee agreed upon is unquestionable, but whether legally liable is another thing, depending as it does upon the general law in New Zealand relating to contracts. We fear that without A holds a written agreement, or that on making the contract a portion of the fee was paid, he will find himself worsted in his action for recovery.—Ed. *A. M. G.*]

DR. OWENS, of Brisbane, at the annual meeting of the Queensland Medical Society, referred to a case of ovariectomy on which he had recently operated. The patient was within two months of eighty years of age. Progress had been uninterrupted. He promised to give a more detailed account in his paper on ovariectomy at the next meeting.

THE MONTH.

FLJL.

SEVERAL changes in the medical department have taken place. Drs. Mann and Dunlop have resigned, Dr. Beith has been placed in charge of Rewa and Navua, and Dr. Skottowe has taken Dr. Beith's place at Levuka. Dr. Pound goes to Ba, and Dr. Armstrong to Taviani.

NEW SOUTH WALES.

A REPORT was received on December 19, by the Sydney Board of Health, that a man named Attwood, porter at The Rock railway station (18 miles S. of Wagga), had been attacked by an illness which Dr. Wren, Government Medical Officer at Wagga Wagga, pronounced to be smallpox of a mild type. Dr. Ashburton Thompson, Chief Medical Inspector of the Sydney Board of Health, visited the patient the following morning, and pronounced the case to be one of chicken pox in a mild form. At the time of his visit the eruption was sufficiently developed to enable him to form a decided opinion. All cause for alarm is thereby dispelled.

In the Legislative Assembly, on December 16, the following motion was agreed to,—“That there be laid upon the table of this House copies of all correspondence between any officer of the University or of the Prince Alfred Hospital and Mr. W. C. Wilkinson, M.P., relative to the appointment of Pathologist to the latter institution, or of Physician to it, since 1st January, 1886.”

RECENTLY representations were made to the Minister for Mines in favour of the introduction of disease amongst rabbits with a view to their extermination. The proposal was regarded by Mr. Abigail with disfavour, and a notification has been published to the effect that heavy penalties will be strictly enforced against persons who introduce diseased rabbits, and that the officers of the department have been instructed to guard against the introduction of such animals.

THE “Dairies Supervision Act” has been extended to the borough of West Maitland, and the municipal district of Adamstown.

DR. A. E. J. BARCROFT has succeeded to the practice of Dr. R. B. Warren, at Moss Vale.

DR. A. H. BARROW, late of Ayr (Qu.), has commenced practice at Booth Street, Balmain, a suburb of Sydney.

DR. R. R. S. BOWKER and DR. A. RENWICK, both of Sydney, have been appointed to seats in the Legislative Council.

DR. H. L. HARRIS, of Raymond Terrace, has removed to Tamworth, where he has succeeded to the practice of Dr. A. T. O'Reilly.

DR. H. C. McDONALL has commenced practice at Newcastle.

DR. A. T. O'REILLY, late of Tamworth, has commenced practice at 46 College-street, Hyde Park, Sydney.

DR. MILLER SEMPLE has settled at Ulmarra, on the Clarence River, 342 miles N. of Sydney.

DR. J. J. STEEL, of 149 Elizabeth-street, has removed to 3 Lyons-terrace, Liverpool-street, Sydney.

DR. R. H. TODD has commenced practice at Waverley, a suburb of Sydney.

DR. G. E. TWYNAM, of 211 Macquarie-street, has removed to 38 Bayswater-road, Darlinghurst, Sydney.

DR. R. B. WARREN, late of Moss Vale, has succeeded to the practice of the late Dr. C. G. Leacock, at Camden, 40 miles S.W. of Sydney.

DR. ARTHUR WATSON, formerly of Clinton and Ross (N.Z.), has commenced practice at Orange.

DR. R. WESTRUM, late of Nyngan, has removed to Young, 250 miles S.W. of Sydney.

NEW ZEALAND.

THE sum expended by the Government for improvement of the Thermal Springs was £7,814 in 1886, and £3,200 in 1887; the amount required for this year is only £300. This is principally for the completion of the water supply at Rotorua, and the planting and improvements of the baths and grounds, and it is not intended to undertake any further works than those at present in hand.

DR. H. MACANDREW, Medical Officer of the Hokitika Lunatic Asylum, has been appointed Certifying Officer for the Vaccination Districts of Greymouth, Hokitika, Jackson's Bay, Kumara, Okarito, Ross, and Waimea, *vice* Dr. King, transferred.

DR. T. M. HOCKEN, of Dunedin, met with a very disagreeable accident last month, when his phaeton collided with a Mornington tram-car; the car crashed right into the light vehicle, overturning it, wrenching one of the wheels off, and throwing the doctor and his coachman violently on the road. Dr. Hocken sustained a severe shaking and a number of very painful bruises and contusions, while his man fared about the same.

HONORARY Surgeon Frederick George Morris Brittin has been transferred from the Christchurch City Guards Rifle Volunteers to the 1st Westland Rifle Volunteers.

DR. B. E. DE LAUTOUR has commenced practice at Tapanui, 98 miles S.W. of Dunedin.

DR. W. R. ERSON has been elected Mayor of Onehunga for the ensuing year.

DR. W. A. FLEMING has settled at Balclutha, on the Molyneux River, 52 miles S.W. of Dunedin.

QUEENSLAND.

AT a meeting of the Croydon Hospital Committee, on December 19, Dr. Alexander Nicoll, of Tambo, was appointed Resident Surgeon of the institution. There were ten applicants for the position.

THE residents of the Barcoo district intend to call a public meeting to endeavour to induce the Commissioner for Railways to grant a medical officer's pass. There are numerous small towns and camps along the central railway line at which the presence of a doctor is oftentimes required, and having to pay the doctor's travelling expenses in addition to his fee comes very heavy upon unfortunates who require his services. This is considered a matter of importance, and, as clergymen are allowed to travel anywhere on a season ticket of £5 or so per annum, there is no reason why the same privilege should not be extended to gentlemen of the medical profession, whose presence is oftentimes more urgently required.

DR. T. N. FLOOD has commenced practice at Beenleigh, 24 miles S. of Brisbane.

DR. S. HAMMOND, late of Cairns, has removed to Toowong, a fashionable suburb of Brisbane.

Dr. T. P. LUCAS, late of South Melbourne, has commenced practice in Brisbane.

Dr. G. O. WILLIS has commenced practice at Barmah, the present terminus of the Queensland Central Railway, 358 miles W. of Rockhampton.

SOUTH AUSTRALIA.

THE ceremony of conferring degrees upon candidates at the Adelaide University was performed on December 21. Dr. E. C. Stirling delivered an admirable address on the aims and methods of biological sciences.

Dr. S. J. MAGAREY, of Adelaide, intends to stand for the Central District at the forthcoming elections for the Legislative Council.

Mr. W. A. VEROO has been appointed Prosector in Anatomy for 1888 at the Adelaide University.

Dr. C. W. HAMILTON, of Gladstone, met with a serious accident on December 27, by his horses bolting and capsizing the buggy, throwing Dr. Hamilton and his coachman heavily to the ground; both were severely shaken and cut about the head, and remained unconscious for some time.

TASMANIA.

AN Act to amend the law relating to Friendly Societies has been passed by Parliament; this Act, which may be cited as "The Friendly Societies' Act, 1888," commenced on December 31, 1887.

VICTORIA.

AT a special meeting of the committee of the Medical Society of Victoria on the 12th December, the following resolution was unanimously adopted:—"The committee of the Medical Society of Victoria learns with great surprise that an important amendment of the Public Health Statute has been introduced into Parliament at the close of the present session, so that copies of the proposed amendment cannot be obtained at the commencement of the week in which, in all probability, Parliament will be prorogued. As far as the committee can learn, the proposed bill would impose important duties on members of the profession in respect of reporting cases of contagious diseases, without enumerating specifically the diseases which are to be reported, or protecting medical practitioners against legal proceedings which may arise from their action under the provisions of the bill. The committee is of opinion that no legislation in this direction can be of effective service which has not the hearty concurrence of the medical profession, and that any attempt to rush such a bill through Parliament is calculated to excite distrust and prevent the attainment, after due discussion, of a satisfactory solution of a question concerning which great divergence of opinion is known to exist." A copy of this resolution has been forwarded to the Chief Secretary.

THE Central Board of Health has recommended that, in view of the great prevalence of hydrophobia in England and Europe, quarantine against dogs should be strictly enforced. This has been approved by the Government.

A DRAFT of the proposals relative to the establishment of federal quarantine has been submitted to the Central Board of Health, and was ordered to be forwarded to the Premier, so that he can, if deemed advisable, lay it before the Federal Council. The proposals

referred to the situation of the quarantine stations, and the manner in which they should be maintained.

THE Central Board of Health recently framed a circular on the causes and the prevention of typhoid fever, with instructions for the management of patients in the absence of medical aid. Copies of this circular have been posted at each of the railway stations, police stations, post-offices, and state schools throughout the colony for general information.

THE Health Officer for Ballarat, Dr. Jordan, recently paid unexpected visits to the dairies from which Ballarat is mainly supplied with milk, and his report upon them is, on the whole, very satisfactory. He visited 42 dairies, with herds ranging up to 60 head. Of the 42 one was found "very dirty," four "fairly clean," and the remainder either "clean," or "very clean," while the largest dairy, that of Mr. Douglas, on the Smythe's-road, where 60 cows are milked, is described as a "model of perfection." The proprietor of the "very dirty" dairy was prosecuted in the local police court and fined.

A WOMAN named Ellen Gardiner at Prahran (Melbourne), was, on December 19, sentenced to six months' imprisonment for baby-farming. Two infants were found in her house in a terrible state, and one is not expected to live.

Dr. A. G. KEOGH, of St. Kilda (Melbourne), has removed from Wellington-street to Barkly-street.

Dr. J. W. O'BRIEN has commenced practice at Elgin-street, Carlton, a suburban city, adjoining Melbourne.

Dr. A. H. STURDEE has commenced practice at Bridgewater-on-Loddon, in an agricultural district, 126 miles N.W. of Melbourne.

Dr. J. E. USHER, late Surgeon Superintendent in the Queensland Immigration Service, has commenced practice at Toorak, a fashionable suburb of Melbourne.

PUBLIC HEALTH.

A CASE of supposed small-pox at Balranald, on the Murrumbidgee River, 554 miles S.W. of Sydney, was reported on January 6, but on investigation by the health authorities it was found that the disease was not small-pox.

THREE cases of typhoid fever have occurred at Port Wakefield (S.A.); every precaution has been taken to prevent spread of the disease.

EIGHT cases of enteric fever were reported to the Victorian Central Board of Health, on December 3, by the Alfred Hospital authorities. During the week five other cases of typhoid and six cases of diphtheria were also reported to the board.

SIXTEEN cases of typhoid fever, of which six proved fatal, and four cases of diphtheria, one of which was fatal, were reported to the Victorian Central Board of Health during the week ended December 18.

DURING the week ended December 24, no fewer than 18 cases of typhoid fever were notified to the Victorian Central Board of Health, three being fatal. During the same period three cases of diphtheria were reported. During the following week ended December 31, sixteen cases of typhoid were reported, four being fatal.

TYPHOID fever has broken out at California Gully, Eaglehawk (Vic.)

THE State school at Specimen-Hill, Sandhurst, was closed about the middle of last month, owing to an outbreak of whooping cough, diphtheria, and typhoid fever amongst the children.

HOSPITAL INTELLIGENCE.

THE Board of Management of the Adelaide Children's Hospital has agreed, on the recommendation of the House Surgeon, to extend the course of training to probationer nurses, under certain limitations, to a period of two years.

THE foundation stone of the new hospital at Goulburn (N.S.W.), was laid by Lord Carrington on December 9; the new building is to be of stone, and will cost £7,000. On this occasion the Governor was presented with a handsome trowel and mallet by the president of the institution, who made a few remarks, in the course of which he pointed out the necessity for a new hospital. He said that from 1877 to 1881, both years inclusive, 581 patients were admitted into the hospital, and during the following five years, that is from 1882 to 1886, 956 were admitted. In other words, in 10 years 1,537 patients were received and treated, at a cost of £7,311 12s. 4d., or at the rate of £4 16s. 1½d. each.

AT a meeting of the Melbourne Hospital committee, on December 13, permission was given to Mr. A. H. McDonald, who has been recently appointed missionary in the New Hebrides, to attend the wards of the hospital to obtain a sufficient knowledge of medical work to enable him to treat ordinary cases of sickness or accident.

THE total amount of the Hospital Sunday Fund, collected in Melbourne in 1887, was £8,676, which was apportioned as follows:—Melbourne Hospital, £2,325 11s. 10d.; Alfred Hospital, £1,373 13s. 5d.; Benevolent Asylum, £868 16s. 1d.; Women's Hospital, £818 14s. 7d.; Hospital for Sick Children, £1,048 9s.; Eye and Ear Hospital, £674 14s. 2d.; Homœopathic Hospital, £562 13s. 9d.; Austin Hospital for Incurables, £501 5s. 2d.; Immigrants' Aid Society, £237 2s. Special votes were also passed to the Collingwood Dispensary of £60, Richmond Dispensary of £50, Convalescent Home for Women of £30, and Convalescent Home for men of £25.

UNIVERSITY INTELLIGENCE.

AT a meeting of the Council of the Melbourne University, held on December 19, a letter was received from the Faculty of Medicine, asking that the salaries of the clinical lecturers should be increased. For the present the fees derived from students for attendance at hospital clinical lectures and *post-mortem* demonstrations amounted to £741 7s., and it was estimated that in 1888 they would amount to £959 10s., besides which there was a Government vote of £500 for clinical teaching. Better provision required to be made for the whole work of clinical teaching. The Chancellor moved that the matter be referred to the medical members of the council. Mr. Ellery said he would oppose any alteration in the arrangements for clinical instruction until full information was afforded the Council as to the hospital practice already given. It was decided, on the motion of Mr. Justice Webb, that Dr. Bromby, Dr. Madden, and Mr. Ellery be added to the committee, and that it be referred also to the committee to inquire and report upon the way in which clinical teaching had been given during the present year.

THE Senate of the University of Sydney, upon the recommendation of the Dean of the Faculty of Medicine, has resolved that the Parliamentary vote of £400 for apparatus for the medical school be appropriated for the benefit of the undermentioned departments, as follows, viz.:—For the museum of normal and morbid anatomy, £175; anatomy and physiology, £100; medicine, £50; surgery, £50; psychology, £25.

OBITUARY.

MR. JOHN JAMES MACGREGOR.

It is with great regret that we record the death of John James MacGregor, M.R.C.S. Eng., 1857, L. et L. Mid. R.C.P. Edin., 1873, who died at Cotham-road, Kew, near Melbourne, on December 11. On his arrival in the colony, more than twenty years ago, he practised first at Dunolly, and afterwards at Daylesford, where he had been residing for nearly sixteen years. The deceased gentleman had attained a reputation throughout this district, not only as a first-class surgeon, but also as a good-natured gentleman and kind friend.

WILLIAM MILLER DICKINSON.

WE regret to have to record the death of William Miller Dickinson, L.R.C.S. Edin, 1850, M.B. Marisch Coll. Aberd., 1852, who died at his residence, Box Hill, near Melbourne, on January 8, in his 59th year. The deceased arrived in Victoria in 1862, and practised for nearly twenty years at Penshurst, in the western district, whence he removed to Box Hill about five years ago.

CHARLES GEORGE LEACOCK.

WE have also to record the death of Charles George Leacock, M.R.C.S. Eng., 1864, L.R.C.P. Lond., 1874, who died at Camden (N. S. Wales), on December 22, from pneumonia, contracted by attending a patient suffering from the disease. The deceased gentleman practised formerly at Lambton, near Newcastle, and also at Moss Vale.

MEDICAL APPOINTMENTS.

- Adam, Alexander, M.B. et Ch.M. Glasg., to be Public Vaccinator at Inglewood, Vic.
 Hill, Alfred William, M.D., to be a Public Vaccinator for Adelaide, S.A.
 Leatham, Henry Blackburn, M.R.C.S.E., L.R.C.P. Edin., to be an additional Public Vaccinator for the district of New Plymouth, N.Z.
 Morton, Francis William Watson, L.R.C.P. et R.C.S. Edin., to be Health Officer for city of Fitzroy, Vic., vice J. R. MacInerney resigned.
 Murray, James Adam Johnston, M.B. et Ch.M. Edin., to be Public Vaccinator for the district of Kaipoi, N.Z.
 Ross, Joseph, M.D., to be Health Officer for shire of Gordon, Vic.
 Semple, Miller, M.B. et Ch.M. Glasg., to be Honorary Surgeon, Ulmarra Reserve Volunteer Light Horse Volunteers, N.S.W.
 Sturdee, Alfred Hobart, M.R.C.S.E., to be Public Vaccinator at Bridgewater, Vic.
 Tripe, William, Borrowdale, M.R.C.S.E., to be an additional Public Vaccinator for the district of Wellington, N.Z.
 Usher, John Edward, M.D., L.R.C.P., Lond., to be Public Vaccinator at Toorak, Vic.

PROCEEDINGS OF COLONIAL MEDICAL
BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Hodgson, Ralph, L.R.C.P. Lond., 1884; L.S.A. Lond., 1884; M.R.C.S. Eng., 1885.
Hughes, Joseph Foorl, M.B. Glasg., 1887; M.S. Glasg., 1887.
Barrow, Arthur Haynes, M.R.C.S. Eng., 1875; L.S.A. Lond., 1875.
Bouchet, Louis Henry, M.B. Edin., 1885; M.S. Edin., 1885.
Goode, Ernest Howard, L.R.C.P. Edin., 1884; L.R.C.S. Edin., 1884.
Corder, Sheppard Ransom, L.R.C.P. Lond., 1879; L.S.A. Lond., 1879; M.R.C.S. Eng., 1879.
Souter, Charles H. J., M.B. Aberd., 1887; M.S. Univ. Aberd., 1887.
Watt, George, M.B. Aberd., 1887; M.S. Aberd., 1887; Diploma in Public Health Aberd., 1887.
MacRoberts, William Kirkpatrick, M.B. et M.S. Royal Univ. Irel., 1887; L.K.Q.C.P. Irel., 1886.
MacLennan, John Norman Emalie, M.B., M.S. Aberd., 1883.

For additional registration:

Chisholm, Edwin, M.D. St. Andr., 1877.

NEW ZEALAND.

Fleming, William Alexander, M.B. et Ch.M. Edin.
De Lantour, Bertrand Edgar, M.R.C.S. Eng.
McLennan, Warwick Guy, L.R.C.P. Edin.; M.R.C.S. Eng., 1881.
Rennie, John Taylor, M.D. Mich. Coll. of Med., Detroit, U.S.A., 1884.
Stewart, William, M.D. Glas.; L.R.C.P. Lond.; L.R.C.S. Edin.

QUEENSLAND.

Müller, Carl.

TASMANIA.

Holmes, Louis Saenger, L.R.C.P. et R.C.S. Ed.; L.F.P.S. Glas., 1887.

VICTORIA.

MaoGillivuddy, Daniel Florance, M.B. Melb., 1887.
Stawell, Richard Rawdon, M.B. Melb., 1887.
Crowther, Frank Smith, M.B. Melb., 1887.
Fraagat, Lionel Francis, M.B. Melb., 1887.
Sitton, Charles Stanford, M.B. Melb., 1887.
Thwaites, Johnstone Simon, M.B. Melb., 1887.
Hayes, Horace Frederick, M.B. Melb., 1887.
Cookson, Joseph, M.B. Melb., 1887.
Jermyn, Frederick David, M.B. Melb., 1887.
Bell, George Lawaluk, M.B. Melb., 1887.
Liddle, Percy Herbert, M.B. Melb., 1887.
Bartley, Joseph Francis, M.B. Melb., 1887.
Goodall, Charles Edwin, M.B. Melb., 1887.
Cardiff, Henry William, M.B. Melb., 1887.
Miller, Joseph John, M.B. Melb., 1887.
Cole, Frank Hobill, M.B. Melb., 1887.
Macknight, Conway Montgomery, M.B. Melb., 1887.
Merrillies, James Frederick, M.B. Melb., 1887.
Craig, Walter Joseph, M.B. Melb., 1887.
Evans, John Herbert, M.B. Melb., 1887.
Moss, William Joseph Aileine, M.B. Melb., 1887.
Ick, Thomas Edwin, M.B. Melb., 1887.
Watson, John Wallace, M.D. 1880, Ch.M. 1887, R. Univ. Irel.
Cocks, Cambridge Cary, M.D. St. And., 1862; M.R.C.S. Eng., 1861; L.S.A. Lond., 1862.

Additional qualification registered:—

Anderson, Alfred V. M., Ch.B. Melb., 1887.

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Experimental Researches in Artificial Respiration in Stillborn Children, and allied subjects. By F. H. Champneys, M.A., M.B. Oxon., F.R.C.P. London: H. K. Lewis, 1887.

Lectures on the Surgical Disorders of the Urinary Organs. By Reginald Harrison, F.R.C.S., Surgeon to the Liverpool Royal Infirmary, &c., 3rd edition, illustrated. London: J. and A. Churchill, 1887.

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A Clinical Study of Neuralgia and of the Origin of Reflex or Transferred Pains. By C. L. Dana, M.D., reprinted from the *New York Medical Journal* for July 23 and 30, 1887.

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Sprains their Consequences and Treatment. By C. W. Mansell Moullin, M.A., M.D. Oxon., F.R.C.S., Eng. Assistant Surgeon and Senior Demonstrator of Anatomy at the London Hospital. London: H. K. Lewis, 1887.

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A Compend of Surgery for Students and Physicians. By Orville Horwitz, B.S., M.D., 3rd edition, illustrated. Philadelphia: P. Blakiston, Son & Co. 1887.

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REPORTED MORTALITY FOR THE MONTH OF NOVEMBER, 1887.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Bronchitis.	Pneumonia.
N. S. WALES.														
Sydney	135,000	285	188	81	2	3	3	...	1	21	19	14	1	5
Suburbs	200,000	804	351	220	10	4	6	...	10	45	21	14	13	7
NEW ZEALAND.														
Auckland	35,965	87	26	5	...	...	...	...	...	2	6	3	4	1
Christchurch ..	15,684	30	13	3	...	...	...	...	...	...	1	2	2	1
Dunedin	24,233	48	20	7	...	...	1	1	1	...	2	1	...	3
Wellington	26,956	74	38	18	...	...	...	8	1	...	4	...	4	2
QUEENSLAND.														
Brisbane	32,571	99	55	44	}	...	...	8	2	62	14	5	3	4
Suburbs	41,082	190	140	90										
SOUTH AUSTRALIA.														
Adelaide	311,258	851	330	147	1	...	7	1	3	42	28	24	13	16
Adelaide	42,904	96	68	21	...	...	1	...	1	10	13	5	...	2
TASMANIA.														
Hobart	31,271	96	46	9	...	...	...	...	4	3	4	3	1	2
Launceston	19,590	57	29	7	...	...	...	...	...	...	4	4	2	...
Country Districts.....	89,712	...	...	...	...	...	...	...	...	...	...	...	...	...
VICTORIA.														
Melbourne	69,774	197	84	241	6	...	6	2	6	52	80	45	22	16
Suburbs	275,606	1022	500											

METEOROLOGICAL OBSERVATIONS FOR NOVEMBER, 1887.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.			Depth.	Days.		
Adelaide—Lat. 34° 55' 33" S. ; Long. 138° 36' E.....	...	100.5	64.8	45.	29.377	Inches	...	...	...	...
Auckland—Lat. 36° 50' 1" S. ; Long. 174° 49' 2" E.....	140.	70.	58.7	46.	...	2.450	18	71	...	...
Brisbane—Lat. 27° 28' 3" S. ; Long. 153° 16' 15" E.	157.	90.7	69.7	54.9	30.030	2.970	29	68	N.	...
Christchurch—Lat. 43° 32' 16" S. ; Long. 172° 38' 59" E.....	142.5	76.6	53.1	34.	...	4.319	18	74	...	...
Dunedin—Lat. 45° 52' 11" S. ; Long. 170° 31' 11" E.....	...	...	...	...	...	...	...	...	...	...
Hobart—Lat. 42° 53' 32" S. ; Long. 147° 22' 20" E.....	...	89.3	56.3	37.0	30.002	1.83	14	77	...	...
Launceston—Lat. 41° 30' S. ; Long. 147° 14' E.....	...	83.5	60.	35.5	30.040	.71	5	77	...	...
Melbourne—Lat. 37° 49' 54" S. ; Long. 144° 58' 42" E.....	...	89.3	58.8	41.5	29.952	3.66	14	...	...	...
Sydney—Lat. 33° 51' 41" S. ; Long. 151° 11' 49" E. ....	...	85.1	64.3	52.2	30.036	5.37	17	72	S.E.	...
Wellington—Lat. 41° 16' 25" S. ; Long. 174° 47' 25" E.....	136.	67.	54.6	39.	...	5.140	16	80	...	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

OVARIOTOMY.

READ BEFORE THE QUEENSLAND MEDICAL SOCIETY.

BY E. MATTHEWS OWENS, M.R.C.S.E., L.R.C.P.
ED., HON. OPHTHALMIC SURGEON TO CHILD-
REN'S HOSPITAL, BRISBANE, AND IPSWICH
AND TOOWOOMBA HOSPITALS.

As I hold a very strong opinion that all papers read before such a society as ours should, as far as possible, be of a practical nature, you will, I hope, pardon me if I leave out all the abstruse parts of the subject of this evening's paper, and deal only with the practical. I hope I may also be pardoned if I seem to dwell too much on minute details, but having during the years 1882-3 assisted Mr. Tait in some ninety-seven abdominal sections, also witnessed thirty-one cases by Dr. Savage and thirty-five by other men, and in all of these cases, especially in those of Mr. Tait, I could not help being more and more convinced that it was due to the rigid attention of minor details. Bearing this in mind, you will not, I am sure, think it necessary for me to say anything about the history, causes or pathology of ovarian tumours, but allow me to go into the practical part of the subject at once.

THE PLACE WHERE THE OPERATION SHALL TAKE PLACE.

Before entering more fully upon this, I may state that no abdominal section should be performed in a general hospital, except under most exceptional and urgent circumstances, unless such general hospital is provided with a separate building where diseases of women are treated, adjoining and yet detached to the same; a small building where only uterine operations are performed and treated quite separately for some seven to ten days after the operation, after which the patient may be taken into the general ward. Any medical man who ventures to do an abdominal section, except the above be provided, undertakes a grave responsibility. To emphasize what I say, I once saw four cases of ovariectomy done in a general hospital, three out of the four died, whereas during the same time, I had seen forty-seven cases done by Mr. Tait and Dr. Savage without a death; the cases should not have died, for they were well and skilfully done, but there was no provision made by the authorities of the general hospital that enabled the staff to keep separate such cases.

OUT-PATIENTS,

too, are a source of poison to abdominal cases. Some years ago the out-patients of The Women's Hospital, Birmingham, were seen on the ground-floor, and in the wards above ovariectomies were done, but the mortality was so appalling that the committee met, and it was proposed that not only should no more operations be performed, but that the hospital should be closed; however, better counsels prevailed, and instead a farm-house was obtained two miles away, the rooms altered to make wards, and three blocks of two rooms in each block were erected, the blocks being quite isolated from the main building; in these six rooms all the abdominal operations were performed, the usual rule being that the patients stayed in the block from seven to ten days after the operation, and then went into the general ward, the room being left ten days empty before a fresh case was put into it for operation; in round figures sixteen patients during the year could be operated upon in each room. Mr. Tait was of opinion that it was the out-patients who caused the mortality in the old building, though everyone else said the wards were saturated with septic poison; at all events, Mr. Tait rented the old buildings and converted them into a private hospital, had the floors scrubbed and the place cleansed, taking no particular care that any antiseptics were used, and in these very wards his operations became as brilliant as before they had been disastrous. I hand you round the sketch of the building, and you will note that it is carefully planned for ventilation, and yet there are no draughts; I think you will agree with me that they are simple; with addition of verandahs, and perhaps being made a little larger, they would be most suitable for this climate, but I would have French lights instead of windows. If you have to operate in private, any fairly large room will do. Mr. Knowsly Thornton says there is no need to make the room bare and cheerless by removal of curtains and carpets, but it is much safer to have neither, even at cost of appearance. A patient has not much opportunity of looking at the floor carpets; at the best they are very doubtful things in a sick-room, and therefore I say be on the safe side and do without them.

THE NURSE

is most important. For choice I would rather have a dull woman than an extra sharp one, for the dull person never thinks, will perhaps carry out your orders faithfully, but the extra sharp one is constantly thinking that she knows a good deal

more than the doctor, and acts upon her own responsibility. Another woman to be avoided is the person who has nursed under this and that doctor; as for ovariectomy, she has seen and nursed hundreds of cases; avoid her as poison, she will assuredly wreck your case, for she will try some of her theories on your patient. I remember such a nurse taking upon herself to administer beef tea by the mouth about six hours after an operation; result vomiting, and her excuse was that some doctor had done so, and *she* thought the patient was weak; I need hardly say she had a bad five minutes with Mr. Tait and was not seen again. Get, if possible, a quiet woman, with fair common sense, not too old, as they get sleepy, and it is your own fault if she does not carry out your directions. Mr. Tait had one nurse for each case, and she did day and night duty; did not leave the patient at all for the first part of the time; she had between each patient a rest of ten days, doing only very light work; it was no great tax. On no consideration allow your nurse to have communication with any person outside the house, if it be in general hospital with the general wards, a most difficult thing to do, and another point against doing cases at all in a general hospital; after the operation, give your nurse accurate directions what to do, allow nothing for her thinking powers—you are the general and she the soldier.

THE DIARY.

Let an accurate diary be kept. By it, should any unfavourable change take place, it can be traced at once, and, if there is a cause, immediately rectified. I hand round the diary of the two cases I shall have to mention at the end of this paper. If you will look at the case of Mrs. S., you will see that there was sudden vomiting on second day, the diary at once told me the cause, arrowroot, instead of gruel, having been given. I may here state that the nurse erred from kindness, as she did not think the patient liked gruel, and so, on her own authority, changed it; had no accurate diary been kept, I should have been puzzled for the cause. I have seen arrowroot produce the same effect before.

WHEN IS THE BEST TIME TO OPERATE?

I must decidedly say the earlier the operation is done the less likelihood of complications, and therefore greater chance of the patient's recovery. Indeed, I consider that there is no capital operation at the present time that has such a chance of success as an ovariectomy performed at the earlier stages of the disease. Some author recommends that all operative interference should be postponed until the patient is quite unable to get about; another, until she begins to emaciate.

Such treatment must be characterised as cruel, making the patient undergo months, and perhaps years, of suffering and misery, when there can be no possible gain in waiting longer in a disease that is sure to be fatal; therefore operate as soon as ever the cyst has risen from the pelvis into the abdominal cavity. By waiting thus long, the intestines that otherwise would be under the incision are pushed out of the way by the tumour, also the peritoneum is put on the stretch, and rendered somewhat insensitve, which adds very much to the chance of the patient's recovery.

PREPARATION OF PATIENT

requires little or none, but see bowels are relieved and bladder emptied; I once saw the bladder forgotten, and it nearly got punctured for a cyst. Do not give quinine or opium to keep bowels locked up, as Thomas recommends. It is a good plan to let the patient sleep the night before in the bed where she will be after the operation, it gets her used to it.

ANÆSTHETIC.

Undoubtedly ether is the best, but it does not do, I am told, in this climate; and I know they cannot use it in India, so that we must stick to chloroform. Mr. Tait gives his ether on a towel, the patient's head being wrapped up, and the ether poured on the face covered by the towel. I must here express my thanks to Dr. Ryan of Gympie, for his hint on injecting ether during the operation; in my first case it was of great benefit, and I am quite sure prevented all shock. Give the anæsthetic in the bed, and have the patient carried to the table; I see Mr. Knowsly Thornton objects to this, and recommends that the patient should walk to the table, and the anæsthetic be given there; his plea for this is saving time, and danger in carrying a patient who is narcotised. All I can say is, he did not practice what he preached when I had the pleasure of witnessing his operations. I have heard so many patients express pleasure at their being put to sleep in their own bed and waking up in the same place with the operation completed, that I strongly recommend it.

TIME OF THE OPERATION.

I made some careful notes whilst I was in Birmingham, where most of the patients are operated upon either at 9 a.m. or 4 p.m., and most certainly the 9 o'clock patients did the best; they settled down before the night and slept better; the nurse, too, is more alert to see any bad symptom, if it should occur within the first few hours. Another great point is that you are fresh, and not tired and fagged, perhaps by a long day's professional work, therefore more likely to perform a more skilful operation than you would in the afternoon.

INSTRUMENTS.

I show you all the instruments Mr. Tait ever had for an ordinary ovariectomy. They are:—12, 18, or 24 sponges, 6 Kœberle forceps, 2 curved needles, 2 Nelaton forceps, 12 straight suture needles, 1 director, trocar, artery and dressing forceps, scissors, Paquelin cautery, 2 or 3 drainage tubes, silk, 1 or 2 scalpels.

Books say you are to have in addition, two bistouries, two directors, two large sac forceps, two tenacula—small, two tenacula—large, sharp hook, second scissors, second trocar, one Peaslee carrying silk, two with braided silk, Iodoform gauze, protector, and lastly a *searcher*. No wonder an assistant is recommended to attend to the instruments, and that they should be covered over so as not to be seen by the patient. As I have said before, only have instruments that you really are likely to use, for more complicated matters. Place all forceps in one shallow dish, the silk, needles, &c., in a second, and the trocar in a jug; pour boiling water on them, and then some 1-40 carbolic acid solution.

SPONGES.

Too much care cannot be exercised in the preparation of these. Sponges used in abdominal sections should on no consideration be used for any other operation. No improvement can be suggested, I think, on Mr. Tait's directions as regards the care and preparation of them, so I give it verbatim. "New sponges are first put into a large quantity of water with sufficient muriatic acid to make the water taste disagreeably acid. They remain in this mixture until all effervescence has ceased, and all the chalk is removed; for this purpose it may be necessary to renew the acid several times. The sponges are afterwards carefully and thoroughly washed to make them as clean as possible, and free from every rough particle; after being used at an operation, they are first washed free from blood, and then put into a deep jar and covered with soda and water (1 lb. of soda to twelve sponges). They are left in this about twenty-four hours (or longer if sponges are very dirty) and then they are washed perfectly free from every trace of soda. This takes several hours' hard work, using hot water, squeezing the sponges in and out of the water, and changing water constantly; leaving them to soak occasionally for a few hours in very hot water greatly assists the cleansing. When quite clean they are put into a jar of fresh water containing about one per cent. of carbolic acid, and after being in this for twenty-four hours, they are squeezed dry and tied up in a white cotton bag, in which they are left hanging in a dry place until wanted."

ARRANGEMENT OF THE PATIENT ON THE TABLE.

The patient being narcotised, is carried in her night-dress with stockings on and wrapped in a blanket to the table, which may be a special one, or two dressing-tables put together will do very well, and do not forget to tie the legs together of the tables. The patient is secured to the table by bandage across the thighs, and the arms are secured by a turn or two of a bandage round one wrist, the bandage is then carried under the back with two or three turns round the wrist, it is then brought under the table and secured to the end left on wrist first secured. A towel is put over the chest and tucked under the night-dress; second towel is put over the thighs and tucked under the blanket which is over the legs. If possible have two nurses to attend to the sponges; one to receive dirty, and hand back clean in a basin, second nurse washing in two or three waters; this seems a simple thing, but without a great lot of drilling they will not work separately and yet together. If the room is big enough, have no one on the same side of the table as yourself, but if there is not room for assistants, nurses, and visitors to be opposite, have your nurses at your side in preference to visitors. On no consideration have an assistant to help you with instruments, except you require the cautery, and then the second nurse could do it. If you have an assistant for the instruments, you are only likely to be bothered.

VISITORS.

Now Mr. Chairman and Gentlemen, I must ask you to take this earnestly what I am about to say:—*If ever you are asked to help or be present at an abdominal section operation, refuse to go, unless, as a man of honour, you can say that for three previous weeks you have not been in any way exposed to infection of disease, or the post-mortem room.* In England you are asked to make a solemn affirmation to that effect, and if you are present as a visitor, never make any remarks whatever, for nothing is so likely to divert the thoughts of an operator as to hear remarks made. I once heard a visitor comparing the operator's skill with another celebrated surgeon. It was very questionable taste, and not kind to the operator. And, lastly, if a visitor, never interfere in the slightest degree with those operating. There is a case on record where a visitor heard a smaller sponge asked for than was given, and he kindly tore one in half; at the end of the operation the sponges were counted, and number was correct, the wound sewed up, and patient died; and the thirteenth sponge that visitor made was afterwards found inside the abdomen.

THE INCISION.

After sponging the abdomen (never shave the pubes), make the incision boldly in the median line between symphysis, pubes and umbilicus, try if possible to hit the linea alba; make the incision from two to two and a-half inches long; after cutting through the skin and fat, pick up a clean sponge and sponge freely the wound, then hand the sponge to your assistant who stands opposite you, and he sponges whilst you pick up each bleeding point with forceps; all being secured, take the dressing forceps and dissect layer by layer until you arrive at the peritoneum; be very careful not to divide the muscles across any of their fibres, as it prevents such close adhesion. If you do not quite hit the linea alba, push on one side or the other with handle of knife until you get it; having reached the peritoneum, pick it up with dressing forceps, make a nick, pass in the director and slit it up the length of the incision; as all bleeding from the incision will now be stopped, take off the pressure forceps, and after rinsing your hands in the basin of clean warm water by your side, pass two fingers as far as possible to see what adhesions you have to deal with; do not use a "searcher" as recommended by some author, your fingers are the best searcher; free any adhesions as much as possible, and make out whether your incision is long enough; and here comes the benefit of the small incision at first, for if you have little or no adhesion you can remove your tumour with a minimum of opening, a much greater benefit to the future of your patient than is generally thought, whereas it is quite easy to enlarge if adhesions require it. After freeing all you can reach round the tumour, puncture, as fluid flows out catch the cyst with large forceps and draw it out; and as it comes to the opening carefully detach any adhesions; do not trouble if some of the cystic fluid escapes into the abdomen, it is a matter of no moment; when you get the pedicle, pass in on either side of it two sponges. Books tell you to use a large flat sponge, but it does not do in practice, for, as you have a small incision, the large sponge pushes the peritoneum too much in front of it; of course it can be used, and is perhaps required where a great chasm is made by an incision of four or five inches, as there is a liability of protrusion of intestines in such an incision.

EMPTYING THE CONTENTS OF THE CYST.

All kinds of plans and modifications have been used. There is Sir Spencer Wells' elaborate trocar. Keith uses a large aspirator. Many German operators simply puncture with a knife, and empty the sac by lateral hand pressure. I

much prefer Mr. Tait's trocar, which is simply a chisel-pointed tube, bent at a rounded right angle, nine or ten inches from the point. Do not turn your patient on her side to puncture, as is recommended. It stands to reason that it is a bad plan, because you have the wound away from the light, and there is a tendency for the bowels to follow the tumour as the sac empties.

PEDICLE.

Three methods of dealing with the pedicle are mentioned—the clamp, the cautery, and ligature. The two former need only be mentioned, for there is not any ovarian tumour that cannot be treated by ligature.

Having passed in the two sponges, transfix the pedicle, and tie with knot—I show you; it is really a Staffordshire knot, but is generally called Tait's—using Chinese silk; divide the pedicle not too close to the knot, after wiping the end to see there is no oozing; drop it into the abdomen, and if there has been much adhesion, pack the abdominal cavity full of warm sponges, take them out and wash, and repeat this until they come out quite clean; after doing this three or four times it must be thought whether it will be necessary to drain or not; if you find that there are still little clots of blood hanging to the ends of the sponges, you had better drain. The same rule applies to draining, as in whist about playing trumps, when in doubt, do it. It retards the rapid recovery of your patient, but it is safer. Having finished the toilet of the peritoneum, as it is called, and decided whether to drain or not, count sponges and instruments, and see if they are correct. Before putting in the sutures, place one or two sponges inside the wound so that the bowels may be kept out of sight, for it will be as well now to cease the anæsthetic, and the sponges prevent any trouble from straining as the patient comes to; the sponges also catch any blood from the stitches. The needles being armed in pairs, it is a good plan to fix them in pairs in a piece of lint—it prevents tangling. After putting in the sutures, carefully withdraw the sponges, and lift up the walls of the abdomen with the sutures, in order to be quite certain that nothing is caught on the peritoneal surface; all being clear, count again the sponges, and then tie the sutures; strap the wound with two or three broad pieces of strapping, and over that a pad of cotton wool, wrapped in gauze, the whole being supported by a binder. If you have to drain, be careful that the tube is placed at bottom of Douglas pouch, and empty it before you apply the pad and binder, which you must put on after patient is in bed. A small piece of hollowed sponge is the best thing to put over the drainage tube.

AFTER TREATMENT.

As soon as the patient has been placed in bed, and if the operation has been a protracted one, give enema of beef tea, brandy, and perhaps some champagne; on no consideration give opiates, as they are not required, and often are a positive source of harm. For first twenty-four hours give ice to suck, and warm brandy and water by mouth; whether you give beef tea enema in first twenty-four hours you must be guided by condition of patient. Second day, gruel and brandy by mouth, beef tea enemata. Third day, minced chop or boiled fish, custard pudding; stop the enema, except perhaps one during the night. Fourth day, increase all food by mouth, and so on day by day; increasing both quantity and frequency of giving solid food. Remove stitches as soon as possible. Empty drainage tube every hour for first nine hours, and then not so often; do not disturb the tube itself until the contents have been quite clear for twenty-four hours, and small in quantity. Do not trouble about the bowels, nature will assuredly show when relief is required, and then she may be aided by 4 ozs. of warm oil injection; passing flatus per rectum must be looked upon as one of the very best symptoms during the whole case. If patient should feel a desire to pass flatus, and is not able to do so, it is a good plan to pass up a long tube, it gives great relief.

NOTES OF TWO CASES OF SUCCESSFUL OVARIOTOMY, ONE BEING ON A PATIENT AGED 79 YEARS AND 10 MONTHS, BELIEVED TO BE THE OLDEST SUCCESSFUL CASE EVER OPERATED UPON.

I have now to very briefly mention two cases of ovariectomy done by me within the last four weeks. The first case was Mrs. S., æt. 79 years and 10 months. On December 2 I was asked to see her, in consultation by Drs. Purcell and Clowes; she was then suffering a good deal of distress from pressure of the tumour. I told her there were three courses open; first, to leave it alone; second, to tap; third, remove the tumour. The patient was quite a heroine, and decided at once

to have it removed. She appeared to be a very good subject for operation, being a thin, wiry woman, of very good physique; and another point in her favour was the extraordinary confidence she had that whatever was done, would be for the best. As far as I could diagnose, the tumour seemed a simple one, and though of large size, I thought there was likely to be very few adhesions. The uterus was freely moveable. After consulting together, on careful consideration we came to the opinion that her chances of recovery would be much greater if she were removed for operation to Miss Doggette's private hospital, which was accordingly agreed to by herself and friends. A very few words will give the subsequent history. On the 8th of December I operated; on the 11th I removed stitches; on the 17th she sat up; on the 21st went home well. The operation itself was not one of great difficulty, because I recognised that it was a parovarian cyst I had to deal with, so did not seek for pedicle, but shelled it out of its capsule. I must say I greatly hesitated whether or not I ought to drain, but seeing how necessary it was to get union by first intention, and considering the age of my patient, I risked it, and the result proved I was correct. This case points to the necessity of an accurate diary. I mentioned before that arrow-root was given instead of gruel, and vomiting was the result. The incision was $2\frac{1}{2}$ inches long, and I did not find it necessary to enlarge it as there were no adhesions. Tumour contained thirteen parts of fluid, and cyst was bilocular. I was capitally assisted by Drs. Purcell and Clowes. Dr. Clowes gave chloroform; I can hardly express how grateful I am to him, as considering length of time patient was under, and her age, it was a great responsibility. It is of the greatest comfort to an operator to have chloroform well administered, as nothing upsets you more than for the patient to be allowed to come from under the influence of the narcotic; the abdominal muscles begin to contract, and the operation has to be stopped. In this case I did not have contraction of the abdominal muscles once. You can see by diary what a careful nurse Miss Doggette proved herself to be; she made one mistake, it was a lesson, and she had candour to acknowledge it in her diary.

REMARKS.

It may be asked, why I operated upon such an old patient? My reply is, that the patient herself decided me; she so wished it, after having weighed the pros and cons of the other two courses. I need hardly tell you that I am very proud of the case, as I believe it to be the oldest case on record, and I am glad for Queensland to have the credit.

THE SECOND CASE.

For the second case I am indebted to my friend Dr. Lyons. Mrs. N., æt. 64, married, no children. When I first saw her case I diagnosed it as likely to be a parovarian cyst, and with a likelihood of no adhesions; but it proved to have adhesions everywhere, and was multilocular. This goes to prove how correct it is what has been so often said, that it is quite impossible to say beforehand what difficulties you may have to encounter in an abdominal section—you may think that you are going to have a very simple case, and yet all kinds of complications arise; another, which you may think will be very complicated and difficult, yet may prove quite easy. I have labelled the specimen on the table as a "parovarian cyst," for, though I tied some structure about size of goose quill, I did not look upon it as a pedicle; I have not examined it, as I did not want to run any risk of getting infected by handling a morbid structure whilst in attendance on the case. I will not enlarge upon this case further, as I hardly consider she is yet quite out of the wood. As you will see by diary, I drained, and was wise in doing so, as the peritoneum is a splendid absorbent gland up to a certain point, but go beyond, and you have a most intolerant region to deal with; and I think there was more oozing than the peritoneum could have borne. In this case I was most ably assisted by Drs. Lyons and Love; the latter gave chloroform for me splendidly. I have confined myself strictly to ovariectomy in this paper, but at some future time I hope to have the pleasure of taking up the subjects of oophorectomy, pyo-salpinx, and hysterectomy.

P.S.—January 25, 1888. Mrs. N. made an uninterruptedly good recovery, and never had one bad symptom; so that I can record it as my second successful case in four weeks, and can now enlarge a little upon it. Mrs. N. was a thin, small woman, fairly healthy; she noticed a swelling in left side about eighteen months ago, which gradually enlarged; she had been subject at times to rather severe attacks of pain, but which opium soon subdued. I operated on her at Mrs. Doggette's hospital on January 5, at 8.30 a.m. Thinking I should have a very simple cyst to deal with, I made my incision two inches long, but as I found that the whole tumour was bound down by adhesions, I enlarged it one-half an inch, making it two and one-half inches in all. The

fluid was dark and rather thick in the first cavity of the cyst, but in the second it was thin and pale, similar to parovarian cyst fluid, and I am inclined to think that it was a true parovarian cyst, and that the fluid in the first cyst punctured had undergone a change from some inflammatory condition taking place in it, and I most certainly found nothing to tie in the shape of a pedicle. As there was a considerable amount of oozing, and I had to pack the abdomen four times before the sponges came out clean enough to close the wound, and even then I thought it would be safer to put in a drainage tube. About three and one-half ounces of fluid was removed from the tube by means of a syringe in the first twenty-four hours; more than I think the peritoneum should have been asked *safely* to absorb. The operation lasted three-quarters of an hour, taking longer than it should have on account of—first, the adhesions; and secondly, checking the hæmorrhage from the broken down adhesions. The cyst contained eight pints of fluid, and was very much thickened, with several small cysts at posterior and lower side. I did not remove the tube until the ninth day, although I removed two of the upper stitches on the sixth and seventh; on the tenth day I removed the rest of the stitches. The tube was left in rather longer than I liked, but up to the eighth day there was two or three drams each twenty-four hours; therefore, I thought it was wise to leave well alone. Her temperature never reached 100°, 99.6° being the highest, on one day only. On ninth day she had stout and oysters. Bowels showed a disposition to act on the ninth day, so they were aided by injection of four ounces of warm oil, which produced a copious motion. Never bother about the bowels not acting; *as soon as ever nature requires relief it will come, without your giving enemas or aperients.* I notice that one writer recommends that rectum should be washed out, to get rid of the debris of the nutrient enematas. All I can say is, I should be afraid to do it, for fear I might wash too much and set up diarrhœa, a most troublesome thing in a patient whose well-being depends so much on being kept in absolute rest. I made my final visit on the thirteenth day, but advised that patient should remain in hospital a week longer, to get up her strength. In conclusion, I am glad these two cases have done well, for I am told that there has not been a successful case in Brisbane for nine years, and many began to think that there must be something inimical in the climate to abdominal sections, whereas I feel quite sure that it was not on account of climate or want of skill in the various operators, but it was really due to the operations being done—first, in unsuitable buildings; and secondly, want of care in minute details of nursing.

CASE OF ABDOMINAL SECTION IN WHICH THE ABDOMEN WAS RE-OPENED ON THE EIGHTH DAY FOR PURULENT PERITONITIS.

By RALPH WORRALL, M.D., M.Ch., Hon. Assist. Surgeon to the Department for Diseases of Women, Sydney Hospital.

THE subjoined case is one of considerable interest. It is an example of one of the latest developments of peritoneal surgery, and enforces the lesson that a "wise courage should ever be the surgeon's motto."

E. F., age 26, a fairly nourished but anæmic-looking young woman, was admitted into the Sydney Hospital on August 31, 1886, complaining of pain in the back, bearing down, leucorrhœa, and scanty, irregular, and painful menstruation, accompanied by fits. Micturition was occasionally frequent and difficult, and she was subject to attacks of "inflammation." Sexual intercourse was invariably painful. These symptoms dated from her last confinement, 2½ years before, the fits beginning about three months after.

She had been married for six years, and had had two children. At the first confinement she suffered from "white legs," at the second from "inflammation," which ended in a discharge from the rectum lasting two months. Menstruation began when she was 18, and the flow had always been slight, irregular, and accompanied by pain, much more severe since confinement. On examination the os was found to be eroded, everted, and lacerated on the right side to the fornix. There was much cervical and vaginal discharge. The uterus was large, tender, heavy, and its mobility slightly impaired. A hard and extremely tender mass occupied the position of the left broad ligament. There was thickening and tenderness in the region of the right broad ligament.

She had had careful treatment outside from several medical men, including myself, without benefit to her condition, and in reply to her urgent questionings "if something more could not be done?" the risks of operation were explained and at once accepted. Her husband, however, refused his consent, and removed her from the hospital on October 15, 1886. She was re-admitted on November 8, much worse in every respect. A violent attack of inflammation had completely broken down her health and spirits, and left her a complete wreck. The uterus was immovably fixed in inflammatory exudation, which could be felt bi-manually to extend half-way to the umbilicus, and was extremely tender.

Perfect rest, blistering, hot douche, and tonics gradually effected an improvement in her general health, but left the local condition practically unaltered; it was therefore determined, at the patient's urgent request, to remove the appendages, which were evidently totally disorganized.

On January 13, 1887, abdominal section was performed. On dividing the peritoneum and passing in the finger, it was discovered that the pelvic organs were indistinguishably welded together by inflammatory effusion, so as to render the detection and separation of ovaries and tubes a task of extreme difficulty. After much patient effort, however, this was accomplished, the left broad ligament being found to contain a cyst the size of a hen's egg. Here I may remark that many observers have noted the frequent occurrence of cysts of the broad ligament in chronic inflammatory disease of the appendages.

The pedicles were secured by interlacing ligatures, and the appendages cut away.

Much time was consumed in controlling the profuse hæmorrhage from the torn adhesions. This was eventually effected by means of sponge-pressure and hot water.

A Keith's drainage tube was inserted, and the wound closed by wire sutures.

There was considerable pain on recovery from the ether, for which morphine hypodermically was administered.

On the third day, as all discharge had ceased, the drainage tube was discontinued. The wound had an inflammatory blush from excessive tension of the sutures, two of which were therefore removed. There was some abdominal distension, but no vomiting. The usual metrostaxis appeared in the evening. Pulse was 130, rather weak, and temperature 101·4. Severe shooting pain at intervals.

On the fifth day pus began to flow from the track of the drainage tube. She looked worn, and the tongue was dry. The pulse, however, had fallen to 108, and the temperature was normal in the morning, but 100 at night.

On the seventh day the temperature shot up to 102·2 at night. She slept badly, and although the temperature had fallen a degree in the morning, it was evident her condition was critical in the extreme. The countenance was anxious, mind depressed, pulse small, and respirations rapid. Pus flowed in quantity from the drainage tube track.

Under these desperate circumstances, after consultation with my colleague, Dr. Chambers—for whose kind help I am much indebted—I decided to re-open and drain the abdomen.

On January 20, the eighth day, an incision was made in the line of the original opening,

which had firmly united, care being taken to avoid intestine which might be adherent to the under surface. On passing in the finger, foetid pus in immense quantity was evacuated. The whole of the abdominal organs were found to be glued together into one mass, enclosing collections of pus which filled the abdominal cavity to the diaphragm. The adhesions were separated as much as possible, and the abdomen thoroughly irrigated with hot water. The wound was then closed as before with wire sutures, and a drainage tube inserted.

The following morning the temperature was normal, but the pulse was very weak, the extremities cold and clammy, and the general condition not at all improved. There was but slight discharge from the drainage tube, owing to the rapid formation of adhesions around it.

On the morning of the second day the patient was much better, and henceforth she slowly but steadily improved, notwithstanding a phlebitis of the left internal jugular, left axillary, and right femoral veins, which retarded convalescence.

On February 9 the drainage tube was removed, and on March 26 she was discharged in fair health, the drainage tube track still discharging pus in small quantity.

On April 26 she reported herself much improved in every respect, but the discharge still continued. The menses had appeared twice in the usual quantity, but with much less accompanying pain.

On May 6 she brought me a ligature which had come away with a gush of pus that morning, since which the discharge had markedly diminished. Her general health continued to improve, and sexual intercourse, which had been so painful, was now a source of gratification.

May 12. Patient was suddenly seized with vomiting and abdominal pain. She was living in Botany in great poverty and hardship, owing to her husband having been out of work. To this I attribute the formation of a hæmatocele in the left broad ligament, which examination showed to be the cause of her sudden illness. She was readmitted to hospital, and under the influence of rest the effusion gradually disappeared. The menses appeared every month in variable quantity, but notwithstanding this, the sudden flushes and other nervous and vascular disturbances characteristic of the menopause were extremely troublesome.

She was discharged on August 22 in fair health, with the exception that the sinus still continued to discharge a small quantity of pus.

She reported on November 22 that she had been very well since. The discharge was a mere watery drain, increasing at the monthly periods,

which continued regularly to recur. The fits still continued to take place, but at much longer intervals than before the operation.

The history of the case given above points clearly to septic inflammation, following delivery, as the cause of all this poor woman's troubles; and it is evident that the extensive laceration of the cervix, which I have mentioned, would render the absorption of morbid matter a not unlikely event.

That recovery was possible without operation I do not think the most sanguine person could imagine. The ovaries were much enlarged, and in the left was developed a cyst the size of a hen's egg. The Fallopian tubes were distended with cheesy matter, and the free ends completely occluded. The whole pelvic contents were matted together by dense adhesions. For such a condition, operation alone could afford relief.

Removal of the uterine appendages for chronic inflammatory disease is an operation which has been but a short time before the profession. Originating in the fertile brain of Lawson Tait, and advocated by his able pen, it has rapidly won its way to a high place in the achievements of surgery. I do not say it is an operation which should be lightly undertaken, or without the most anxious consideration and patient trial of other means, but I would urge that when this has been done, and the pelvic organs are still found to have their structures altered and functions perverted, it is our duty to place before the patient a mode of treatment by which, with a moderate risk, she may hope once more to share in the enjoyments and duties of life.

I should not call any operation highly successful in which the convalescence had been so protracted as in this, but it must be remembered that the procedure in this case was of exceptional difficulty, and that if the patient had been able to have even ordinary care after her discharge, in all probability the hæmatocele would not have developed, and recovery would have been complete ere this.

Why the menses should regularly recur when the ovaries and tubes have been completely removed, as in this and other recorded cases, is a problem for which no sufficient explanation has as yet been offered. That they will do so for the normal period of menstrual life is, I think, highly improbable.

A year or two ago no surgeon would think of re-opening the abdomen after operation because the case was doing badly, and my object in publishing this interesting case is to note how to-day the great principles of surgery are applied to every part of the human body, not excepting even the peritoneum.

NOTES ON SOME OF THE RARER COMPLICATIONS OF GONORRHOEA.

By R. A. STIRLING, M.B., &c.

COWPERITIS.—A young man with a urethritis of four weeks' standing, consulted me with an undoubted Hunterian chancre on the glans. He was taking copaiba capsules for the discharge. Five days afterwards he suddenly felt a feeling of weight in the perineum, with a small swelling most marked on the left side of the raphé. He was ordered rest and evaporating lotions. The swelling increased, the areolar tissue surrounding it becoming hard and painful. On the third day after its appearance a tenotome was pushed into the tumour, followed by the escape of a good deal of blood, but no pus. A probe inserted extended several inches laterally towards the ischial tuberosity, and forward along the course of the urethra. This cavity was injected out with a solution of carbolic acid (1 in 20), a drainage tube applied, and the wound dressed with iodoform. The pain on any movement was, for a day or two, severe, but the wound had closed, and all the swelling, save the lateral hardness, had disappeared by the end of a week. The constitutional symptoms at first were out of all proportion to the extent of the local mischief. He lost in weight, 20lbs. in 11 days.

The danger in this rare disease is of the abscess opening into the urethra, hence my reason for making a small incision even before the pus had formed. There is nothing to be gained by a large opening in so septic a locality.

ORCHITIS.—True orchitis is fortunately as rare, as epididymitis is common, in gonorrhœa. It is nearly always associated with the abuse of copaiba or sandal oil in lymphatic subjects. There are two symptoms accompanying it, which, apart from the local signs, are diagnostic: the agonising pain, and the obstinate constipation. One man recently under my care passed neither flatus nor fæces, per anum, for ten days, in spite of the strongest purgatives. I began to suspect intestinal obstruction. There is one drug which, if it can be retained, is always effectual as a purgative—castor oil in large doses. The pain is not

relieved by position, lotions, nor with nauseating doses of tartar emetic, nor salicylate of soda. I find morphine hypodermically, and the application of twelve or more leeches to the inflamed gland, more satisfactory than even an ice-bag, which is useful in the early stage.

One of the worst cases of orchitis I have met with occurred in an elderly gentleman after the simple tapping of a hydrocele; he had had a gleet discharge from the urethra for years. The swelling of the gland was excessive, and for almost a fortnight extremely painful, but on complete recovery a month after the tapping (the first and only one) the hydrocele was gone.

Orchitis ending in abscess must be very rare and is hardly ever spoken of in books. In the solitary case I have met with, a strong young man of 20, the abscess, which was limited, involving the anterior and lower part of the gland, slowly contracted and healed, leaving the testes in a very tender and hardened state for months.

Superficial abscesses about the rectum occur so frequently in patients who have just recovered from a gonorrhœa, or in whom it is declining, as to make them more than coincidences. Those that have come under my notice are usually dorsal, arise suddenly, especially after the sudden subsidence of the discharge on taking an anti-blennorrhagic. The pain and difficulty in walking are excessive. It is quite likely they occur in persons prone to pulmonary inadequacy. Small as they look externally they require an anæsthetic before opening, on account of the severe pain and the probable depth of their burrowing, even when existent but a few days. The sphincter, unless an opening into the rectum can be detected, never requires division in this disease, as the cavity rapidly heals when dressed properly, and its cutting draws out the healing to weeks. Iodoform is the best application, dusted well into the incision.

Recently I have seen a gentleman, æt. 49, with a history of gonorrhœa many years ago, who suffers from abnormal erections, due to the formation of two small hardened nodes in the corpora cavernosa. They are painful at times, and render him practically impotent. He himself is quite positive as to their relation with the urethritis; but Van Buren and Keyes, who describe a somewhat similar condition, believe that it has no venereal origin. Its rarity, however, may be imagined, when they state they have seen but four cases. Von Zeissl speaks of a syphilitic affection of this character, but states that treatment is of no avail. I should be glad to hear of cases of a like nature, and the nature of the remedies adopted.

Melbourne, January, 1888.

THE USE AND ABUSE OF ANTISEPTIC IRRIGATIONS IN MIDWIFERY PRACTICE.

By F. W. ELSNER, L. ET L. Mid., K.Q.C.P.I.,
F.R.C.S.I.

IN No. 46 of the *Berl. Klin. Wochenschrift*, for 1885, Reimann published a paper on this subject, the conclusions he arrived at being :—

1. That the so-called prophylactic uterine and vaginal irrigations are superfluous in child-bed, if the latter be conducted aseptically.

2. That such irrigations have been found to be dangerous in normal child-bed, both from theoretical deductions and practical experience.

3. That a single irrigation undertaken by the accoucheur himself immediately after the confinement, may, in rare cases, *e.g.*, existing decomposition of the uterine contents, be both necessary and advantageous.

4. That nurses (midwives) should never be allowed to carry out uterine or vaginal irrigations on lying-in women. Impressed with the importance of these conclusions, with which I now thoroughly agree, I have ever since reading Reimann's paper adhered to his principles, and I can dispose of the cases in which I have found it necessary to use either vaginal or uterine irrigations in a few sentences. Of 254 cases I have conducted since January, 1886, up to January, 1888, there were 40 abortions, 10 cases of premature labour, in three of which live children were delivered, and are now alive, and one death, the particulars of which are as follows : a dwarf in stature, patient had a narrow pelvic brim ; funis presentation ; reduction by Thomas' method ; prolapse repeated ; membranes ruptured ; long forceps applied, but ineffectually ; turned and drew down cord ; head jammed in pelvic brim ; forceps again, but useless ; as cord ceased to pulsate, perforation and delivery with blunt hook ; rupture of vagina and perineum ; lacerations repaired there and then with carbolic sutures ; irrigation with warm carbolic solution (3%), conducted by myself twice a day, in spite of which extensive sloughing of the vagina took place, and although I brought in my own nurse, as the family were too poor to pay for one, death ensued on the 6th day from exhaustion, owing to want of appropriate nourishment, and the absence of a proper nurse during the first two days and a-half. In all cases of abortion in which the ovum or secundines were not rapidly expelled, or there was severe hæmorrhage and a patent os, the finger was invariably used to separate and extract the contents of the uterus, after which a uterine

irrigation with plain hot water at from 100° F. to 110° F. took place, and in no case did a rise of temperature ever follow, nor was a second irrigation necessary. Confident that the cases have been conducted aseptically, I have never used an antiseptic except in the case just mentioned ; but, of course, it must be admitted that hot water is an admirable antiseptic itself, and if so, why use any other ? I have, since 1886, seen no case of septicæmia in practice in Australia, and I think that in private practice, *ceteris paribus*, such cases need not, and certainly should not occur as Playfair recently pointed out.—(*British Medical Journal*, Nov. 12, 1887). Of the cases other than abortions there was one of placenta prævia, in which the vagina was plugged, and it is remarkable that this is the only case of the whole series, including abortions, in which I have used the plug, which is both dangerous and superfluous if frequently resorted to, as I know it to be in cases of hæmorrhage, no matter from what cause. The forceps were applied in 32 cases, 6 of which were face to pubis, 2 of difficult labour from 4th position of the head, and 8 in which the forceps were applied to the aftercoming head successfully, the children being all resuscitated, and including twin boys. Not a single case of post partum hæmorrhage has occurred, and this I account for by rigid adherence to the Dublin practice of manual expression of the placenta, to which I add the administration of a large dose of ergot as a matter of routine, the latter administered either immediately before the child is born, due time having been allowed for the distension and relaxation of the perineum, or immediately after the head is safely delivered.* And I am happy to find that Playfair has recently advocated this plan, to which, as he says, no reasonable being can have any objection. Apart from many other arguments in its favour, the ergot once having acted, the accoucheur can leave his patient with the same feeling of security that Professor Stokes, of Dublin, says he leaves a patient whose severed femoral artery he has secured with a whipcord ligature ; then again, proper contraction having been obtained there are undoubtedly fewer after-pains to suffer, and this alone should be a recommendation to those gentlemen who desire to establish their reputation as skilful accoucheurs in the eyes of their lady patients. Prior to the cases mentioned as having occurred since 1886, I was in the habit of using prophylactic irrigation, and other methods of treating abortion and difficult labour to those I have described ; the results not being particularly brilliant, I hailed Reimann's paper with delight, and in order to test the accuracy of

* Chloroform I have not used more than a dozen times, and in seven of these it was given by another practitioner.

his statements I have kept record of every puerperal case I came in contact with, and I think the results are as good as any that can be produced. With one or two exceptions I have always carried out Thomas' plan of repairing every injury to the perineum which extends beyond the fourchette, at once, care being taken to bring the edges of the internal (intravaginal) portion of the laceration well together in order to prevent the blood and lochia from lodging in the pouch formed by the laceration and the external line of sutures, and causing non-union. Silver wire is invariably used. In the one fatal case I used carbolised catgut to stitch the ruptured vagina, but the sutures all gave way and caused ulceration in several places, which silver, no matter how much blackened from H_2S , never does. But rupture of the perineum should be very rare indeed if the perineum is properly supported, and I will here at once dogmatically assert that the accoucheur who passes his fingers into the rectum for the support of the perineum cannot possibly pretend that he has conducted the labour aseptically. It were better either to incise the perineum if it seems likely to tear, or to let it take its chance and to repair it after delivery, than to run the woman's life into danger by a procedure both useless and disgusting, as well as extremely unpleasant to the sufferer at the time. It is in the endeavour to neutralise the effects of such unclean midwifery that accoucheurs resort to the uterine and vaginal antiseptic douche, but this fails them, and they throw up their hands in horror at the idea of anyone speaking of the service of antiseptics, either in midwifery or other practice. In the good old days before Listerism there were no irrigations in use, and yet a number of obstetricians had long runs of cases without septicæmia, and they were certainly innocent of antiseptics; however, they knew what was nearly as good, and that is the value of cleanliness, of good surroundings, and of what we now know as asepticism generally. (The late Dr. Jewel used to convert the patient's best drawing room into a lying-in chamber, and, says Dr. Barnes, "I have often turned it to profitable account.") Nay, further than that, they believed in what is now totally ignored by irrigationists, and that is the necessity of physiological rest for the uterus and parturient canal after delivery. If we examine into the state of affairs following the third stage of labour, we expect to find the uterus diminishing, contracted, and the os pretty hard and unexpandable, whilst a free discharge of blood takes place for several days, but with no trace of smell other than that of blood; perhaps there are clots or there may be sanguineous fluid, in any case the discharge is aseptic as it is designed by nature to be. The discharge

continues for a month as a rule, during which time it undergoes various changes in colour and consistency; but it remains aseptic throughout if not interfered with, and providing the woman has not been poisoned from some cause or another, which we will not now stop to further enquire into. This then is the normal lochial secretion, destined by nature to bathe the bleeding, perhaps lacerated and over-distended genital tract, to keep the bared placental surface of the uterus free from noxious elements, or possible contamination by contact with the acid secretion of the vagina, which would retard the formation of mucous membrane in the uterus and lay the seeds of leucorrhœa hereafter, and above all to prevent the entrance of air into the vagina and uterus by force of gravity and exhaustion of these cavities. It is "meddlesome midwifery" with a vengeance when a large irrigation pipe is introduced into the uterus after delivery, and that organ is irrigated twice daily when it should be allowed perfect rest, and the confinement has been normal in every respect. If the hand has been introduced into the uterus for the removal of the placenta or portions of membranes it may be well to undertake a single irrigation immediately after delivery, or if the contents of the uterus are already decomposing when labour takes place; but it would be curious to ascertain when these conditions have not necessitated it, what the idea of those accoucheurs, who irrigate invariably after delivery, can be in carrying it out. To my mind it argues want of confidence on the part of the accoucheur in his own ability to conduct a case aseptically, if he has resort to antiseptic irrigation after normal child-bed. What are the drawbacks to this procedure?—I. It is *unnecessary* (1) if the hands and instruments of the accoucheur and nurse have been previously disinfected with 3% carbolic solution; (2) if the external genitals of the puerpera be sponged with the same solution; (3) if, instead of lard, oil, or other lubricant, boric acid ointment, made with lanoline,* the only indecomposable fat, and vaseline, be used for the fingers and hands; (4) if the patient be kept at perfect rest after all lacerations have been repaired and her knees be kept close together. II. The procedure is *injurious*, (1) by admitting air into the genital tract; (2) by disturbing the physiological rest of the uterus and vagina; (3) by washing away the protecting lochial secretion from the placental site, and re-opening fissures and small lacerations thereby, channels of absorption thus being laid bare; (4) by carrying into the uterus any pent up secretion which may have collected in the posterior cul-de-sac of the vagina, which is notoriously irritating, but which, when

*Lanoline is shown to be antiseptic itself.—*B.M.J.*, Dec. 10, 1887.

diluted by the lochia, is washed away naturally without interfering in any way with the healing processes. (N.B.—It is this vaginal secretion chiefly, which, if it sickens through the sutures of a repaired perineum, renders the operation abortive). (5) The irrigation pipe passed into the uterus keeps the cervix constantly dilated, and by tearing asunder the edges of lacerations received during labour, prevents union taking place, which is still further retarded by the vaginal secretion aforementioned working its way into the fissures of the cervix. By this means the patient is placed in the condition after child-bed for which Emmett's operation has been devised, and it certainly seems significant that almost every lady, nowadays, who has had a few confinements, has had to undergo Emmett's operation at some time or other within the last four or five years, to my own certain knowledge. Gynæcologists may, perhaps, not have cause to grumble at such a state of affairs; those who have wives, and married relatives, to say nothing of short purses, may look at it from a different point of view. To those who would hear other opinions on this subject of aseptic midwifery, I would recommend the study of Playfair's, Barnes', More Maddens' and Byers', addresses to the obstetrical section of the B.M.A. at Dublin (*B.M.J.*, Nov. 12, 1887), and the discussion thereon last year. Space does not permit me to analyse these opinions now; but a study of this paper will readily show the points in which I differ from them, which are not many, and may be largely owing to the differences in practice necessitated by residence in Victoria, with its variable and yet salubrious climate. When I studied at the Rotunda Hospital in 1880 and 1881, the use of the douche had not materially lessened the death-rate which has only recently fallen to below 1 per cent, the difference having been caused through the enforcement of stringent rules for the students, who are not allowed into the wards if engaged in dissections or other pathological work. Even this, however, could be allowed if we were certain of proper antiseptics being carried out by those who attend the dissecting and *post-mortem* rooms, for Fritsch has reported that he daily dressed a putrid wound on the person of his brother for a year, and although he performs two or three obstetric operations daily, he has never had a case of puerperal poisoning, owing to the antiseptics he observes in regard to his own person, not that of the puerpera. The latter is almost always aseptic until the unclean hand of the accoucheur or nurse has contaminated her. The Dublin practice has been fully described by Dr. Macan, Master of the Rotunda Hospital, Dublin, in the *B.M.J.* for August 20, 1887. To summarise, then, what we have been discussing: (a) it is proper for the accoucheur to disinfect

himself and the nurse and not his patient, unless the uterine contents are decomposed, and then it is sufficient to irrigate once with whatever antiseptic fluid he favours. (b) Interference after normal labour is injurious to a high degree, and supererogatory if a has been observed. (c) All irrigation *when necessary* should be carried out by the accoucheur himself, undertaken as few times as is possible, and, in the case of the uterus should be conducted by means of a tube of the calibre of a No. 10 catheter only. (d) Hot water at 100° to 110° F. should be used in preference to all other antiseptic solutions when a deodorant is not also required, and the vaginal plug should never be used unless it is impossible to check hæmorrhage by other means, *e.g.* the removal of the cause; or when it is necessary to gain time for cervical dilatation, Barnes' bags not being available, *e.g.* in placenta prævia. (e) Such lacerations of the parturient canal as can be stitched without subjecting the patient to much inconvenience, *e.g.*, perineal ruptures, should be operated on immediately after delivery, silver wire being used. Good hygienic precautions in regard to the patient having been enforced, the accoucheur, who observes the rules just laid down, may rest assured that septicæmia or any form of puerperal poisoning, *e.g.* cellulitis, pelvic peritonitis, and the rest, will not occur in his practice except through a combination of circumstances it may be impossible to guard against.

Richmond, Melbourne, January, 1888.

HYDROCEPHALUS.

By JOHN L. SPOFFORTH, M.R.C.S.E.,
L.R.C.P. Ed.

On January 4, 1887, I was called to visit Mrs. C., æt. 19, the wife of a wharf labourer, a strong, healthy-looking woman, who was pregnant with her first child. Subsequently I gathered the following history: After the cessation of the menses she had constant sickness. This symptom continued up to the third month. Between the third and fourth month it appears she was upset by family affairs, and she had a bad shock. Her appetite failed, and she was unable to get about very much. On New Year's Eve false pains commenced, which continued until Tuesday morning, January 4, when true pains came on, and the liquor amnii escaped between 10 and 11 a.m. She was attended by a midwife. On examination the os was about the size of a five-shilling piece, the head was presenting, and the pains were strong and forcing in their character. I dilated

the os, and tried to apply Barnes' forceps, but found the handles would not meet. I then passed my hand into the uterus, and discovered the dimensions of the child's head was enormously increased in size. I perforated the head, and the labour terminated in less than two minutes.

The head contained several pints of fluid; the mother made a good recovery. The specimen is in the University Museum.

Playfair says the diagnosis of intra-uterine hydrocephalus is by no means so easy as the description in obstetric works would lead us to believe.

As regards diagnosis, the points noted in this case were as follows:—

Pains—Frequent, strong, severe, and forcing.

Head—Increased in size, stationary, soft and compressible.

Sutures and fontanelles—Wide.

Caput succedaneum—After the os was fully dilated, almost filled the vagina.

Pelvic deformity—Absent.

Forceps—Slipped, handles would not meet.

Argyle-place, Sydney.

MENTHOL IN LARYNGEAL PHTHISIS AND OTHER DISEASES.

By A. J. BEEHAG, B.A., M.B. ET CH.M. ED.,
CLINICAL ASSISTANT, EAR AND THROAT
DEPT., EDINBURGH ROYAL INFIRMARY.

It is now nearly two years since A. Rosenberg, of Berlin, brought before the notice of the "Berliner Medicinischen Gesellschaft," his menthol treatment in connection with pulmonary and laryngeal phthisis, and in a paper read before the same society on April 6, 1887, he confirmed his former statements from the results of his more extended clinical experience since that date.

A twenty per cent. solution of menthol in olive oil is the strength generally employed. Olive oil will take up more than twenty per cent. on heating, but the menthol will recrystallise when exposed to a low temperature, and the mixture form a solid mass. Slightly warming will cause it to redissolve, and in this manner we can use the drug in a highly concentrated form. The solution is injected into the larynx, directly on to the part affected, under the guidance of the laryngeal mirror. The syringe, devised by myself, and made by Gardner of Edinburgh, serves for injecting the fluid both into the larynx when it is the seat of the disease, and into the trachea when the lung only is affected. It is better, especially

in the case of laryngeal phthisis, to make two or three injections of about ten minims in each, at one sitting. By this means more prolonged contact of the agent with the diseased tissues is secured. After each injection the patient should be made to take deep inspirations, whereby the cooling and anæsthetic effect produced by the menthol is accelerated. No danger whatever results from such an endolaryngeal method of treatment, and no untoward or disagreeable effects follow the introduction of such large and concentrated solutions of menthol into the system. The patient at first feels a slight burning sensation in the larynx, which is quickly replaced by a cool, pleasant feeling, and in a few moments a warm sensation is experienced all over the chest, due to the solution finding its way into the lungs, which it does; according to Reichert's experiments of a series of twelve endotracheal injections on calves and sheep, even to the finest bronchioles. This should be performed at first every day for about two months, and the treatment by injections should be continued by inhalations of five minims, or as much as the patient can bear of the same solution in a pint of steaming water. These inhalations should be used frequently, if possible every hour during the day in the early part of the treatment. A convenient method, also, is to make the patient wear a piece of cotton wool wetted with the solution before the mouth and nose. The patient sometimes finds it more convenient to sleep with this on during the night.

Menthol possesses, in a marked degree, the anæsthetic action of the oxy-hydrocarbons of the volatile oils. A few minutes after its application, pain and other uneasy sensations in the larynx disappear, and that *bête noir* in laryngeal phthisis, viz., dysphagia is combated to such an extent that the patient is at once enabled to eat without pain. The effect of this can be readily appreciated. Nutritious foods can be taken into the system, and the general health of the patient thereby improved. With regard to the anæsthesia produced by menthol, Rosenberg has pointed out a very important fact, viz., its cumulative effect. "After the first injection," says Rosenberg, "the anæsthesia lasts from one to three hours, after the second or third still longer, so that after a week the effect lasts for a whole day." The antiseptic properties of menthol, also, are very marked, as has been experimentally proved by Koch and other observers upon various forms of bacteria. Rosenberg has demonstrated its distinctive effect upon Tubercle Bacillus by exposing pure cultivations of this organism to the influence of menthol in a gaseous form. Shortly after the beginning of the treatment, one sees an improvement in the condition of the patient. If the larynx be the seat

of the disease, the hypersecretion soon becomes diminished, and the whole surface of the larynx becomes much cleaner. This is also shared by the ulcers, which finally heal, leaving beautiful smooth cicatrices, better than one sees after the use of lactic acid; but there are certain cases which don't yield to treatment so readily, and these are marked infiltrations and hypertrophies. These yield better to the application of lactic acid, but even here, the resistance to treatment is very great, and is greatly accelerated by first curetting the infiltration with Hering's laryngeal curette, and afterwards by the employment of either menthol or lactic acid, or of both. I say both, because menthol is a very useful adjuvant in the lactic acid treatment, where it should be injected two or three minutes before the application of the acid. By this combined method a quicker result is obtained, for even by itself the lactic acid brings about quicker cicatrization of the ulcers. But there are certain advantages which the menthol has over the lactic acid treatment. The former, if precisely applied with the laryngeal syringe (and not with the brush, which causes pain), is not unpleasant to the patient in its application, and when the subjective symptoms in the larynx are subdued, some few minutes afterwards, the patient's spirits are raised, and the appetite at once manifests itself, especially if dysphagia were a symptom, so that the patient, as has frequently been my experience, gets to enjoy the treatment. In the case of lactic acid, where one must apply the remedy accurately and vigorously for a few seconds (best done by a piece of cotton wool affixed to Krause's Kehlkopfpincette or to Hering's Tamponträger), one can readily understand that such vigorous treatment is not at all unaccompanied by pain. As for the patient losing flesh during the application of lactic acid, which has been asserted by some, I must say that such has not been my experience, and I have had a large one in this branch in Krause's Clinique in Berlin.

What, also, is to me a very important advantage in the menthol over the lactic acid is, that in the former the medicament is not confined to one spot, but extends over a large surface, viz., the whole of the larynx, trachea, bronchi, and bronchioles. A case in point will illustrate the fact. At the "Society of Naturalists and Physicians," held in Berlin, 1886, Hering, of Warsaw, produced a larynx to show that he had cured a laryngeal ulceration by the lactic acid treatment, but which showed suspicious points in other parts of the larynx, and which were pointed out by Professor Chiari, of Prague, as being probably miliary nodules. These points were afterwards microscopically examined by Virchow, who pronounced them to be tubercular. Certainly the

tubercular ulcer had been healed in this case, but the tubercular disease had not been wholly exterminated from the larynx.

Besides improvement and cure in the laryngeal condition, a similar result is also obtained in the pulmonary condition, if the patient comes early enough under treatment. Directly after the injection the patient experiences a remarkable freeness and lightness in breathing. The sputa, during the course of the treatment, gradually lose their nummular character, become less and less purulent and finally disappear. There is a marked diminution in the cough, and an improvement in the voice. The night sweats diminish, the bodily weight increases, and the system generally is improved. Rosenberg relates the very interesting case of a patient affected with both laryngeal and pulmonary phthisis in its early stage, who was treated by him with menthol. This patient afterwards presented himself to be examined by a well-known expert of a Life Insurance Company, and on the strength of this examination was enabled to insure his life in the ordinary manner. I can give an unqualified confirmation of the good results of the Rosenberg method of treatment, since, through his kindness I have treated many of his patients, and watched the results for many months. One should not give up the treatment too early, though later the applications may be made less frequently. Of course it is not pretended that very confirmed cases of phthisis can be cured by this method of treatment, but its employment here relieves many of the distressing symptoms. The sputum is more easily expectorated, the coughing much alleviated, and the morbid processes for a time retarded. With the object of procuring prolonged contact of the agent with the larynx in phthisis laryngea, especially when there is much secretion present, I have introduced a powder to be insufflated. Its composition is as follows:—Menthol, 3ss., Ammonium chloride, ʒjss., Boracic acid, ʒj.; misce fiat pulvis. This powder, when pulverised very finely, is very useful in chronic laryngeal catarrh. In the form of snuff, a pinch of it may be taken frequently into the nostrils for acute and chronic nasal catarrh, and will be found to cause a great diminution in the purulent secretion. Directly after it is taken, a flow of watery mucus is induced, and thereafter the nose remains cool and free. The marked antiseptic properties of this snuff, and its power of causing a copious secretion, led me to use it in idiopathic ozæna, and the results obtained have been very satisfactory. The horrible foetor is quickly removed, and the frontal headaches disappear. The nose becomes freed from crusts and its mucous membrane will be seen to be in a moist condition and of a more healthy

aspect. The snuff should here be taken frequently, and the secretion which follows its use should be retained in the nose with the object of softening the crusts and rendering their expulsion easy. If they have been previously expelled, this precaution will prevent their reappearance. The patient should also be enjoined to draw the powder back through the nose into the mouth with the object of reaching the crusts in the nasopharynx, and of relieving the dysphagia, and hawking one to the concomitant pharyngitis sicca. If, by way of experiment, some of the powder be insufflated into the naso-pharynx, the pharynx which was previously dry and shining will now be seen to be bathed by a copious moist secretion.

Menthol is a vascular stimulant and quickly reduces swelling of the smaller nasal mucous membrane. It also possesses the power of what Jelineck pointed out with regard to cocaine, viz., of reducing erectile swelling of the inferior turbinated bone, by emptying the cavernous tissue of its blood. Thus menthol is indicated in those cases of nasal obstruction due to these causes, and will be found to be extremely useful in those cases of rhinitis, associated with a purulent secretion, so commonly met with in scrofulous children. Some short time ago, a woman came to me complaining of her child suffering from "snuffles," with inability to sleep and suck properly. The other members of the same family showed distinct evidences of syphilis, and the child itself was being treated for the same disease by the family doctor. On examination I diagnosed the case to be syphilitic rhinitis in the first stage, and ordered the interior of the nose to be painted several times daily with a five per cent. solution of menthol in olive oil; the effect was immediate; the child could suck with ease, slept soundly, and showed other signs of general improvement. The importance of rendering the nasal passages clear in sucking children, with the distinct benefits which accrue, as in the case just mentioned, need not be dilated upon.

Menthol has a decided action in relieving the pain and swelling in acute catarrhal angina. A twenty-five per cent. solution of it in olive oil should be copiously applied to the pharynx by means of a large soft brush. The pain and dysphagia are relieved, the patient is enabled to secure sleep, and the attack is cut short. In some cases, the speedy subsidence of the swollen and inflamed tonsils has been remarkable, without any abscess formation. If there be acute rhinitis accompanying the disease, the solution should be painted into the nostrils also, the strength of the solution I use, for this purpose being from five to twenty per cent., according to the age of the patient.

In cases of chronic pharyngitis, with local or reflected pains, I use the well-known Mandl's formula, with menthol superadded; the prescription I use being as follows:—Iodine grs. vi., Potass. iodid. gr. xx., Aqua 3iii., Menthol 3jss., Glycerine 3vi.; misce. The menthol here is suspended in a state of fine subdivision.

As might be expected from the action of menthol in other forms of neuralgia, I have found it to give relief in otalgia by dropping a strong solution of it, in olive oil, into the ear.

Australasian Club,

Edinburgh, December 8, 1887.

PROCEEDINGS OF SOCIETIES.

MEDICAL SOCIETY OF QUEENSLAND.

THE ordinary monthly meeting was held in the School of Arts, Brisbane, on Tuesday, January 10, at 8.30 p.m. Present: Drs. Little (President), Owens, Shout, Jackson, Lyons, Gibson, Hill, Hammond, Thomson, W. S. Byrne, Taylor, Campbell, McNeely, and Love (Secretary).

DR. THOMSON showed a specimen of Saccharine, the new sweetening reagent.

DR. LITTLE returned thanks to the Society for the honour done him in electing him President for the ensuing year.

DR. THOMSON showed a patient, aged 37, who had consulted him for a cold in the head, and who exhibited the following remarkable condition:—When the mouth was open, a peculiar bubbling sound, comparable to the bubbling of boiling porridge, was audible, synchronous with the heart-beats, there being a double sound like the two sounds of the heart. Had phthisis 21 years ago in the left lung, and was told by the doctor who examined her for emigration that the "left lung was gone;" heart's apex outside left mammary line; a distinct rasping thrill in left at the inner edge of the scapula; left apex dull on percussion; vocal resonance increased; resonant patch anteriorly between apical dullness and upper line of heart dullness.

The noise is aggravated by ill-health and by damp weather. It is distinctly audible across the room; no evidence of aneurism. Some discussion followed, in which some members thought that there was consolidation of the lung near the upper margin of the heart, with a cavity communicating with a main bronchus, and the heart-sounds were transmitted through this. Against this was the fact that the noise was heard when she was 12 years old, before the lung-mischief had commenced. Others thought it due to a congenital malformation of the heart, with existence of a communication between ventricles.

DR. OWENS showed 3 cases of Dislocation of the crystalline lens, and DR. BYRNE showed a small uric acid stone, which he had taken from a boy *æt.* 2 years 4 months, by suprapubic lithotomy; also 3 small rounded gravelly concretions, passed by a babe 4 months old.

DR. WM. KERBELL, of South Brisbane, was elected a member, and DR. PURCELL was nominated for membership.

DR. OWENS then read his paper on Ovariectomy, with the notes of two successful cases, which will be found on page 107.

SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

MONTHLY Meeting, held at the Adelaide Hospital, January 26, 1888.

Present :—The President (Dr. Davies Thomas), Drs. Cawley, Gardner, Lendon, Mackintosh, Mitchell, Poulton; Messrs. Aitken, Bickle, Clindening, Corbin, Finnis, Anstey Giles, Hayward, Lawrence, and the Hon. Sec. (Mr. Cleland).

The minutes of the meeting held October 27, 1887, were read and confirmed.

BALLOT.

W. BALY, M.R.C.S. Eng., was elected a member of the British Medical Association, and of its South Australian Branch.

EXHIBITS.

DR. POULTON showed a man on whom he had operated in October last, for compound dislocation of the astragalus. The bone had been forced forwards and outwards by a severe fall, and the distended skin was slightly torn. Failing to effect reduction, he removed the bone, after lengthening the existing wound. The patient was able to wear a boot and bear some weight on the damaged foot, which would apparently gradually acquire useful strength.

There was remarkably little alteration in the general contour of the instep and ankle, and no ankylosis of the new joint.

MR. CORBIN exhibited a patient suffering from exophthalmic goitre, with all the marked characteristic symptoms. As Dr. Gardner intends operating later on, it was thought that the members might like to see the pre-existing condition to compare with any subsequent result.

DR. LENDON brought before the members a case of buphthalmos.

PAPERS.

DR. GARDNER read the notes of a successful case of total extirpation of the larynx, performed by him for cancer. He also showed a vulcanite artificial larynx, made by Dr. Woodburn, especially for him, at Dr. Newman's request. It had been modelled after Foulis' original instrument. The ordinary silver instrument looked alarmingly big and heavy in comparison.

MR. CLINDENING referred, in flattering terms, to Dr. Gardner's skill as an operator. He thought that South Australia should feel proud that the only two cases of total removal of the larynx in Australia had been performed by an Adelaide surgeon, with such brilliant results.

MR. CORBIN thoroughly endorsed the remarks of the last speaker. He confessed that he had always felt puzzled as to why the removing of a portion of the larynx was often more successful than removing the whole. Judging, *a priori*, he should have thought that the fact of leaving behind a portion of tissue identical, in every respect, to the diseased structures, was almost like courting a return of the disease. For his part, therefore, he should always recommend a perseverance in the plan of total removal whenever a case occurred justifying operative measures.

MR. HAYWARD asked what would be the symptoms making the operation a justifiable one, and what amount of spread of the disease would make it futile to operate. He thought that the future success of the operation, as one of the standard operations, would depend very much upon suitable cases alone being taken. Unsuitable ones would simply mean certain

failure, and thus undeserved odium would be thrown on a possibly valuable operation.

DR. DAVIES THOMAS raised the point as to whether the operation could be called a justifiable one. Personally he knew nothing about the matter, but he thought it was a matter of importance to the profession to consider the ground on which it would be judged by the outside public. He thought that as regards English surgeons there was a consensus of opinion against it—a feeling that the average result was not sufficiently good. He would refer to Dr. Morell McKenzie's book on the subject. The great question was did it sufficiently prolong life to make it worth while running the great risks incurred. That should be the basis on which it should be judged. As an example he would refer to Keith's remarks on the justifiability of operating for fibromata of the uterus. Just before leaving London, two years ago, his friend, Dr. Felix Semon, had operated on Mr. Montague Williams, removing a portion of the larynx. At the same time Dr. Semon had strongly expressed his opinion that as a rule he did not consider the operation a justifiable one. Dr. Thomas regretted that he did not remember what had been the circumstances making it justifiable in Mr. Williams' case.

DR. GARDNER, in reply, said that nothing would have pleased him better than to have been able to answer Mr. Hayward's queries. He said that was just what they had yet to find out. He did not set himself up as an authority on the operation, as he did not consider that he had had yet sufficient special experience. Taking all the cases on record, they did not yet exceed one hundred. Hahn, of Berlin, had operated upon fifteen cases, nine in which the larynx was partially removed, and six in which there was total extirpation. One of these latter had made a complete recovery, and had survived the operation, as yet, seven years. If, therefore, even one in fifteen had no recurrence of the disease, surely that was enough to justify the operation. In judging of the opinion of English surgeons, great stress must be laid on the miserable, foggy, damp climate of England. In Great Britain there had only been as yet two successful cases of complete laryngotomy, all the others had been failures. And these two cases had been operated on in Scotland. It was very natural, therefore, that there should be felt a certain amount of disinclination on the part of English surgeons to attempt it. He thought the profession was not yet in a position to decide either for or against it. What he would recommend was, that surgeons should go on working, and, after a time, the necessary data would be forthcoming. As regards the operation itself there was nothing very formidable about it, if only the operator had familiarised himself with it before-hand, by operating on the cadaver. He must acknowledge that his first case was rather disappointing in its results; but then it was a very unfavourable subject, as the disease had already lasted two years. If the prolongation of life should be found to be only of ten months duration, the operation would certainly not be justifiable. He hoped, however, for better things.

DR. LENDON then read his notes on a two-mouthed monster, which will be published in a future issue of the *A.M.G.*

A TREELY qualified man (London qualifications) is desirous of obtaining an engagement in one of the Australian colonies. Has had extensive experience in private practice—would prefer a large town—has no objection to take an assistantship where an ultimate prospect of a partnership would be held out. Address —H. A. Reed, Waipawa, Hawke's Bay, N.Z.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, FEBRUARY 15, 1888.

EDITORIALS.

LAYMEN OR DOCTORS ON BOARDS OF HEALTH.

THE actions of the Victorian Board of Health are a delicious commentary on the frequent assertions of unthinking laymen that it is unwise to intrust the regulation of quarantine to medical men, for the reason that they would be especially liable to enforce quarantine without giving due consideration to the rights and convenience of commerce. This Health Board, which has a layman for President, and has an unusually small proportion of medical men amongst its members, is the one which the most unnecessarily and arbitrarily makes use of the power it possesses of enforcing quarantine. A short time since, during the outbreak of small-pox in Tasmania, it decided to treat that colony as a foreign country, and insisted that all persons arriving from it should undergo the regular detention in cases of variola, whilst during the present month it has induced the Victorian Government to proclaim the Northern Territory of South Australia an infected country, because, forsooth, some Chinamen have been landed there from steamers from China, though they are kept in strict isolation. Anything more absurd, unfair, and uncalled for than this action it is impossible to imagine, and it is difficult to realize on what grounds the Board arrived at the decision to act as they have done. On the same principle, if they were consistent, they would proclaim Auckland an infected port, because of the case arriving by the "Mariposa," and Sydney because it has patients suffering from small-pox at its quarantine station. How different has been the

conduct of the Board of Health in Sydney, composed almost entirely of doctors, it, though exercising a proper care for the public health, has always avoided unnecessary restriction, and, excepting the first few days of the Tasmanian outbreak, whilst awaiting information unduly delayed in its transmission from that colony, has been satisfied with inspection on the arrival of vessels. It has very properly considered it right to treat the whole of Australia as being but portions of one community, and has only taken the same precautions it would have done in the case of one of the towns of the colony if an outbreak occurred in it. The Victorian Board attempts to justify its course by asserting that it followed the example of that of New South Wales. This is in fact, a misstatement, for, with the exception of the first few days in regard to Tasmania, Sydney never enforced quarantine at all. The truth is the former Board blindly followed the lead of the latter acting in emergency, and had either too much obstinacy or too little intelligence to reverse its action when the occasion for it had ceased to exist. We can only hope that the useful, though shocking, example of this lay Board will not be lost sight of when the question as to the merits or demerits of the appointment of medical men to deal with health matters comes up for discussion.

THE MEDICAL BOARD OF WESTERN AUSTRALIA AND INFANT MORTALITY.

IN December last a series of resolutions, of an extremely useful and practical character, were passed by the Medical Board of Western Australia. They have been published by direction of His Excellency the Governor, and widely distributed in that colony.

Infant Mortality is in a great measure dependent on the ignorance which prevails as to the proper treatment of young children, and anything which tends to spread correct knowledge on the subject must be an efficient aid in the preservation of life. The first paragraph relates to the deaths which occur through the attendance of drunken and incompetent midwives, and this evil is equally rife in the other colonies. The second points out the danger from unsuitable and ill-prepared food; whilst the fourth calls attention to the administration of narcotics by nurses and other unskilled persons, and makes a suggestion to decrease the facilities for obtaining them. We congratulate the Board on its action, and Western Australia that it has gentlemen who act so practically for the benefit of the colony which they serve.

LETTERS TO THE EDITOR.

SIR MORELL MACKENZIE ON THE
USE OF CHLOROFORM IN TRACHE-
OTOMY.*(To the Editor of the Australasian Medical Gazette).*

DEAR SIR,—I have had great pleasure in reading the November number of your journal, which contains so many excellent original articles, beside other interesting matter.

As a specialist, however, my attention has been particularly called to Dr. Scot-Skirving's valuable paper on tracheotomy. I agree with nearly everything in it, but I wish to raise my voice against the use of chloroform. I have performed the operation of tracheotomy between seventy and eighty times in former years, and I consider that the use of a general anæsthetic enormously increases the danger in opening the air passages; the fact is that, when hæmorrhage takes place in the throat and the patient is under the influence of an anæsthetic, the reflex act of coughing does not take place owing to the anæsthetic state of the air passages, hence the patient becomes suffocated because nature is unable to make use of her powers to prevent the occurrence of this accident. I have seen several patients die during the operation of tracheotomy, simply from the use of chloroform. Ether is even more objectionable as it irritates the air passages, and in those cases where there is embarrassment of respiration it so produces its effects, that it becomes dangerous to wait till these are fully established.

I have always found simple freezing of the surface quite enough, but if more complete local anæsthesia is desired, the subcutaneous injection of cocaine, after using the ether spray, will produce absolute insensibility during the entire operation.

Yours truly,

MORELL MACKENZIE, M.D.

19 Harley Street,
Cavendish Square, W., London,
January 8, 1888.

SWALLOWING A PIN.

(To the Editor Australasian Medical Gazette.)

SIR,—The following case may be of interest to some of your readers.

On the evening of January 1, 1888, a female child, aged twelve years, came to my surgery, stating that she had swallowed a pin. I immediately passed my finger into the throat, but failed to detect any pin. I was able to make a very careful laryngoscopic inspection, owing to the throat not being over-sensitive, and the child

affording me every assistance in her power. I was unable to see anything of the pin.

I then passed my finger very deeply into the pharynx, and far down could detect a pin well imbedded, with the point directed upwards and forwards, too far down to be removed by my finger. The probing, forceps, and the vomiting of a large solid meal, all failed to shift the pin, but caused it to become imbedded almost to the head.

The child during these operations had been in the sitting posture. I now laid her across a bed with her head hanging over the edge, and in this position I forced two fingers into the throat and succeeded in extracting a pin $1\frac{1}{8}$ inch long.

The child experienced immediate relief, and lost only a small quantity of blood.

The child has since suffered no inconvenience, with the exception of a sore throat for a few days. She is now quite well again.

The interesting feature in this case is the pin being so deeply imbedded, and the ease with which it was removed by placing the patient in the position described.—I am, sir, yours faithfully,

STANLEY TRESIDDER,
M.R.C.S.E, L.R.C.P. Lond.

Glen Innes, N.S.W.,

January 10, 1888.

DRUMINE.

(To the Editor of the A. M. Gazette).

PURE DRUMINE has not as yet reached the market. The demand for the drug continues to be great both from the Continent and America, and my own experience up to date gives me unabated confidence in the alkaloid. I have therefore resolved to place the first specimen of the drug on the market, and with this end in view, Messrs. ROOKE, TOMPSITT and CO., of Melbourne and London, are, under my supervision, by a process slightly modified, engaged in its manufacture. It will, therefore, at a very early date, be in the hands of the profession for trial on its merits. The rapid development of fungi on the plant has deterred me from exporting, and has caused more than usual care in the collection and manufacture of the article soon to be placed on the market. It will be remembered that properties purely relating to the paralyzing of sensory nerves are claimed for the drug, with freedom from constitutional symptoms. It is useful in sprains, in toothache, in sciatica, in catarrh of the stomach and bowels, and eczema of the scrotum. Local application, once or twice, of an aqueous or spirituous (rectified or proof) solution to each nostril will almost immediately cure a common cold. [This is a unique action?] Spasm of sphincter ani, painful wounds, burns and scalds are in its province. Application of pain producing drugs to wounds, &c., will have a valuable adjunct in this alkaloid.

The acetate is perhaps not quite so soluble as the chloride.

JOHN REID, M.A., M.D., &c.
149 Collins-street E., Melbourne, January 7, 1888.

THE USE OF MORPHIA BY HOMŒOPATHS.

(To the Editor of the A. M. Gazette.)

SIR,—Upon a fatal case of dysentery which occurred recently in my practice, and which was reported in our morning paper in the most sensational American style, the Editor of the *A. M. Gazette*, in last month's issue, bases some harsh comments, some unfair inferences, and one important error, to all of which I now submit a reply, as this article going forth to the medical world uncorrected, will work to my prejudice both in the colonies and at home. As to the general question—the use of morphia by Homœopaths,—I do not assume any responsibility for other practitioners of my own school, and if any assertions in my letter of 1884 are too sweeping or too dogmatic, I withdraw them, in the cause of unfettered personal medical liberty.

But as to the case of Mrs. Cole.—1st. I do not habitually carry a hypodermic syringe, but on this occasion brought it at my evening visit, because the patient was so very much worse at the morning visit, that I feared morphia *might* have to be used. The syringe had not been used in my practice for six months previously, and then only to tide over the passage of a gall-stone, which was attended with agonising pain.

2nd. Being of opinion that the "Injectio Morphinæ Hypodermica" of the British Pharmacopœia is too strong and unsafe to be commonly used, seeing that 5 minims (containing $\frac{1}{4}$ grain of morphia) is as small a quantity as can be conveniently used hypodermically, I make from this B.P. "injectio" a diluted solution, by adding two volumes of aqua distillata to one volume of the "injectio." This was the actual dilute injection used to Mrs. Cole, the 5 minims injected contained, as you will see, exactly one sixth of a grain of the acetate of morphia.

This explanation, which no doubt the consultant will confirm, disposes of the "one important error" I above mentioned—namely, that I had given one-half a grain in solution, hypodermically.

3rd. In bare justice to myself I must state that the reporting of the case to the police, and the sensational way in which the *Herald* took it up was due to the fact that the ignorant people of the house who "nursed" Mrs. Cole were unaware, as they alleged, of her extreme danger, and were so horrified at the use of the hypodermic syringe (as Irish, I understand, usually regard this mode of using morphia), that they declared that Mrs. Cole was poisoned! As an outcry against the doctor is a spicy sensation to some people, and as the *Herald*, I presume, was in want of a local sensational article, the most was made of this occurrence. Several of the leading allopaths came to me and expressed their warm sympathy for the unwarranted annoyance and worry caused by the *Herald's* publication. Far more fair and honorable was the allusion of the evening papers to the case. From a leader in the *Evening Bell*, of Auckland, I excerpt the following:—"We think it is greatly to be regretted that so much has been made of a very ordinary case of death which recently occurred from dysentery."

Notwithstanding every effort on Dr. Moore's part, Mrs. Cole succumbed to the disease, and some seven hours before her death, to relieve the pain, when all other remedies had failed, the very ordinary remedy of an injection of a small dose of morphia was administered under the skin, and over the chief seat of pain. This appears to have relieved the suffering, and given quiet sleep, which was all, it appears, that was to be hoped for in the circumstances; for being an aged woman and wholly prostrated by the debilitating effects of the disease, she continued to sink and died. Another medical practitioner of the other school of medicine,

Dr. Girdler, was called in consultation some hours before the decease, and his opinion is perfectly clear that the death was the natural result of the exhaustion caused by dysentery; but it appears that some ill-advised friends were injudicious enough to bring the matter under the notice of the police, from whom it passed under the notice of the coroner, Dr. Philson. That gentleman, after consideration of the case, decided that there was nothing whatever to warrant a coroner's inquiry, and we cannot but express regret that what has been simply an ordinary case, has, by being brought under the notice of the police, been given a publicity for which there does not appear to have been a shadow of a warrant."

My full statement (written for the coroner, not for the newspapers) of the homœopathic treatment, ought to satisfy all practitioners and supporters of that system that I had thoroughly and accurately selected and tried the remedies suitable for the illness, which had begun *two and a half days before* I was called in. On the 25th November, I adopted the *next best* means known to me to give her a last chance for life, and failed. The dose was most certainly very moderate, and by no possibility could it have caused or accelerated the fatal issue. We are all liable to errors of judgment, and should make allowance for one another.

MURRAY MOORE, M.D.

Auckland, January 31, 1887.

(To the Editor Australasian Medical Gazette.)

DEAR SIR,—I shall feel obliged if you will kindly rectify one or two slight errors you have made in the Editorial, "The use of morphia by homœopaths," in the January issue of the *A.M.G.* The statement I made to the Coroner was as follows:—

"Dr. M. Moore informed me that he had injected 5 minims of his own preparation of morphia, which he said was made of one part of Injection of Morphia of the British Pharmacopœia, and two parts of water—so that 5 minims contained one-sixth of a grain of morphia." (This he called his dilute, "Injectio Morphinæ.")

I also said that one-sixth of a grain of morphia was a correct and proper dose under the circumstances, and had nothing to do with the cause of death. I am still of that opinion, although I think the patient might have had a better chance of recovery if it and other suitable allopathic medicines had been given earlier. I may say that I had nothing to do with the previous treatment of the case, the patient being in a state of collapse, and died soon after I saw her.

G. FOUSSAINT GIRDLER.

Kyber Pass, Auckland, N.Z.

[THE "important error" complained of by Dr. Moore was made in what the New Zealand *Herald* publishes as Dr. Girdler's official report, in it he speaks of five minims of the Dilute Solution of the British Pharmacopœia. The only Hypodermic Injection of this pharmacopœia contains $\frac{1}{4}$ grain of morphia in every five minims, and we naturally concluded that he meant what he said. As to Dr. Moore, it is singular that, though according to his statement published in the same paper, and introduced as having been made by him at special request—this being the only one which we have seen, for, strange to say, he has not sent us his statement written to the coroner, which he says would satisfy everyone—he would have preferred giving opium by the mouth had he had it with him, he should have had the forethought to take a hypodermic syringe, whilst he neglected to bring the preparation of opium, which he would have wished to use had he had it there. We do not, for a moment, suggest that in giving the morphia Dr. Moore did not do what was advisable for the

patient; but we agree with Dr. Girdler, the consultant, in his opinion that it is to be regretted that "it and other suitable allopathic medicines had" not "been given earlier." We trust our readers will appreciate the charming naïveté with which Dr. Moore says he left off the remedies he most believes in to try the "next best means known to me." Most men stick to the best, and do not go to the next best. As to the withdrawal by Dr. Moore of the statements made in his letter of 1884, we think it does not amount to much, as it is only when they tell against himself that he does so, and it is but a fair inference that they would have been sturdily maintained had not circumstances rendered them inconvenient.—*Ed. A.M.G.*]

ELECTRO-MAGNET OPERATION ON THE EYE.

(To the Editor of the A. M. Gazette.)

SIR,—Dr. Schwarzbach's successful operation with the electro-magnet in removing a piece of iron from the interior of the eyeball (*vide A. M. G.*, Dec. 1887), seems to have given no rest to a Dr. John Wilkins, of our city, who in the *Auckland Evening Star* of January 17 intimates that such an operation is a kind of every day occurrence to him. If he would have been satisfied with this assertion it might have been well and good, and even medical men may have believed the statement to be true. Unfortunately for the inventive doctor, he at the same time describes the manipulation of using the electro-magnet—at least the manner in which he pretends to have used it. He says: "About six or ten cells of a Leclanche battery (voltaic) answer the purpose very well. (Remember it must not be interrupted or Faradic). The patient holds one electrode in the hand, and the wire of the other must be attached to magnetise the soft-iron rod used in extracting the foreign body from the inside of the eye."

Now, Mr. Editor, such an ignorance of the laws of electro-magnetism is remarkable in a medical man who signs F.R.C.S. behind his name, and still more remarkable is the audacity with which he proclaims his unscientific ideas. An electro-magnet operation, as described by Dr. Wilkins, is quite impossible, for the "soft-iron rod" (as he calls the magnet at rest) cannot be magnetised except both electrodes touch the poles of the electric coil; the body of the patient has nothing whatever to do with magnetising the rod. It would be well for the doctor to return to college to restudy the fundamental laws of physical science.

I enclose my card, and remain, &c.,

SURGEON.

Auckland, January, 1888.

MEDICAL FEES.

(To the Editor Australasian Medical Gazette.)

DEAR SIR,—I enclose you an account on which I should like your opinion. The fee to the man's house is and always has been 10s. 6d., 1s. being paid by me each journey for puntage. The man has been lying about his account, and I wish you to say in your valuable paper if 18 journeys, medicines, &c., constant attendance on a case of most acute pneumonia, brought successfully through in a most unhealthy patient, is exorbitantly paid at £14 2s.

If you will kindly return the account after examination (for which I enclose stamps), and publish your opinion in the *A. M. G.*, you will greatly oblige.—

R. G. ALLAN.

Raymond Terrace, January 10, 1888.

[We think the account a fair one, and can only suppose that the patient, considering himself a better judge of the value of his life than anyone else, believes that £14 2s. is more than it is worth.—*Ed. A. M. G.*]

REVIEWS.

LIFE AND RECOLLECTIONS OF DR. DUGUID.

EDITED BY JOHN SERVICE, L.R.C.S. and P. Ed.
Edin.: Young J. Pentland.

THIS is a book which will interest Scotchmen and lovers of the Scottish dialect, but let no unfortunate and untutored Southron suppose that its title indicates a book easily intelligible to him.

The chief interest of the book lies in its homely but expressive dialect, and in the delineation of the individual eccentricities of character so typical of the country parishes and villages of Scotland, and here associated with the little country town of Kilwinning. Such eccentricities only the genius of provincial dialect may worthily express, and the character sketches of them here presented give to this book its real title to the attention and interest of the reader. It is true the writer professes to narrate a life, but the continuity of his narrative is a quite subordinate feature of his book.

Dr. Service has evidently painted from life, and the appreciative and duly qualified reader will have little difficulty in recognising if not the specific, at least the generic, type of many of the characters, whilst the pithy phraseology cannot fail to evoke a thrill of sympathetic feeling in the heart of the Scottish reader, who still lovingly cherishes the spirit of "his own, his native land."

QUIZ-COMPEND OF SURGERY.

By DR. ORVILLE HORWITZ. Philadelphia:
Blakiston, Son & Co., 1887. 3rd Edition.

THE demand for a third edition of this little book indicates that it has proved, in some degree, useful. As its name implies, it is a compendium of surgical knowledge within the space of 200 pages, and is clearly and succinctly written. It is also carefully revised up to date, and contains many of the most recent additional details of the science.

Some of the articles are quite admirable statements of facts; and the directions for treatment, if somewhat dogmatic, are not on that account less useful to students.

The illustrations are abundant and valuable, being taken, with permission, from the standard works on surgery.

THE MEDICAL BOARD OF WESTERN AUSTRALIA AND INFANT MORTALITY.

THE following resolutions passed by the Medical Board of Western Australia, as to the high rate of Infant Mortality prevailing in Western Australia, with suggestions as to remedial measures, have been published by direction of His Excellency the Governor, Sir Fred. Napier Broome, K.C.M.G. :—

1.—That one of the causes of Infant Mortality arose from the attendance of drunken and incompetent midwives ; and the Board suggests that in towns where qualified assistance can be obtained, the cause of every infantile death should be ascertained by means of a Coroner's Inquest.

2.—The next and chief cause of this excessive mortality arises from unsuitable and unwholesome food. The natural food of the infant being milk, failing that of the mother too much stress cannot be laid on the necessity of substituting some form nearly approaching it—to the exclusion of starchy foods ; this is afforded by cow's milk, properly diluted, and, failing this, good condensed milk. This latter is sometimes to be preferred to cow's milk, which is apt to acquire disagreeable properties at certain times of the year.

3.—With reference to the nourishment of children, a leaflet with plain instructions to mothers, to be prepared by the Board, should be handed by the Registrar in every case of registration of birth.

4.—Another and gravely important factor is the frequent practice of administering narcotic patent drugs, and as a means of somewhat diminishing the facility of obtaining these pernicious compounds, the Board would suggest that certain preparations, as enumerated, should bear a largely increased duty ; these are :—

Steedman's and Stedman's Soothing Powder, Dalby's Carminative, Winslow's Soothing Syrup, Chlorodyne, Cherry Pectoral, Pectoral Balsams, and other preparations which may hereafter be proved, to the satisfaction of the Medical Board, to contain opium or other narcotic drugs.

ALFRED R. WAYLEN,

Perth, 12th December, 1887.

President.

MR. L. BRUCK, Medical Bookseller, Sydney, has just received a full supply of "Carter and Frost's Ophthalmic Surgery," illustrated with a chromograph and 91 engravings.

MEDICAL PRACTICE, old standing, easy terms—in Melbourne—splendid opportunity for a good pushing man.—Apply Medicus, Post Office, Brisbane.

HOSPITAL INTELLIGENCE.

THE new wing of St. Vincent's Hospital, Sydney, was formally opened at noon on Saturday, January 21, by Lady Carrington. There was a very large assemblage of visitors, including his Eminence Cardinal Moran, several archbishops and many bishops of the Catholic Church, the Right Hon. W. B. Dalley, P.C., Lord Bertie, A.D.C., Sir Patrick Jennings, Sir John Robertson, K.C.M.G., and others. Lady Carrington was accompanied by the Countess of Carnarvon. The new wing is built in the Italian style ; verandahs above and below, running nearly the whole length of the hospital, supported on Ionic columns. The main entrance is at the junction of the two wings, and is flanked with handsome Corinthian columns, surmounted by three pediments and a dome. The entrance hall measures 27 feet by 20 feet, and has a parquetted floor, elaborate cornices, and a large quantity of handsome, yet utilitarian, ornamentation. A staircase of carved cedar runs up in front, and on either side corridors, waiting-rooms, &c., flank off right and left. On the ground floor is the operating room, numerous private rooms, bathrooms, an ophthalmic room (containing 10 beds), a large ward for women (containing 30 beds), two nurses' rooms, presses, and magnificently appointed lavatories and bathrooms. At the extreme end is an emergency isolation ward. The upper story contains a library 27 feet by 20 feet, six bed and bathrooms, an expansive ward for females 99 feet 9 inches by 23 feet 9 inches (containing 40 beds), and the usual nurses rooms and accessories. The building is of brick on stone foundations, and for coolness sake, it has a slated roof. Ventilation appears to be faultless, and each of the rooms is not less than 16 feet in height. Water, hot and cold, is supplied in abundance, while fire preventers, lifts, telephones, electric bells, &c., are also at hand. With the opening of this new wing the Sisters will be able to receive nearly 100 additional patients, the whole hospital having now 200 beds.

DURING the year ended December 31, 1887, 237 in and out-door patients were treated at the Goulburn (N.S.W.) Hospital.

At the Melbourne Hospital during the past year 15,926 persons have been treated as out patients, and 3,593 have been admitted to the wards. Of this number 2,628 have been discharged cured or relieved, 123 have left as incurable or for various reasons, 574 have died, and 268 remained in the institution at the close of the year. Of the fatal cases 179 died within 72 hours of admission, and 173 patients died of phthisis out of 387 cases suffering from that disease. Of typhoid fever patients there were 430 treated throughout the year, the mortality being 13.95 per cent.

At a recent meeting of the Committee of the Alfred Hospital, Melbourne, a letter was received from the town clerk of St. Kilda, on behalf of the St. Kilda Borough Council, asking for information with regard to the admission to the hospital of patients suffering from typhoid fever. It was resolved to reply that such patients would be received on the same terms as had been agreed upon with the Prahran City Council, viz., 30s. per week for medical attendance, nursing, medical comforts, &c., the Council to provide tent accommodation.

THE hospital at Sandhurst (Vic.) has received a bequest of £40,000 from a former resident of that city.

THE Bairnsdale (Vic.) District Hospital was formally opened for the reception of patients on February 2.

The foundation stone of the Thargomindah (Qu.) Hospital was laid on February 2.

THE MONTH.

NEW SOUTH WALES.

DR. T. C. BENNETT, late of Moonta (S.A.), has removed to Broken Hill, the centre of the famous silver mines in the Barrier Ranges.

DR. C. A. D. CLARKE, of North Shore, has resigned his office as Honorary Physician to the Sydney Hospital, held by him for the last four years.

DR. E. H. GOODE has settled at Port Macquarie, in an agricultural and wine-growing district, 256 miles N. of Sydney.

DR. G. T. HANKINS, of Sydney, has removed from 3 Lyons-terrace, Hyde Park, to 49 Phillip-street.

DR. J. L. DE LAMBERT has commenced practice at Ebbley-street, Waverley, a suburb of Sydney.

DR. R. H. TODD, who lately commenced practice at Waverley, near Sydney, left for New Zealand, on January 19, as medical attendant to Sir John Hall.

DR. G. WATT, a recent arrival, has settled at Kempsey, on the Macleay River, 296 miles N.E. from Sydney.

NEW ZEALAND.

DR. A. H. NEILL, Medical Superintendent of the Seacliffe Asylum, Dunedin, has been requested to resign. Dr. T. R. King, of the Mt. View Asylum, Wellington, is to succeed him, with a salary of £50 less than Dr. Neill received. Dr. Hassell, of the Wellington Hospital, takes temporary charge of Mt. View Asylum.

DR. W. ALLAN, a new arrival, has settled at Mosgiel, in a fine agricultural district, 10 miles S. of Dunedin.

DR. JOHN DEYSDALE, of Port Chalmers, has been appointed a member of the Otago Dock Trust.

QUEENSLAND.

THE following practitioners have been added to the list of magistrates:—Dra. G. Comyn and J. L. Cuppaide, both of Roma; M. E. Fitzgerald, Springsure; D. S. Macdonald, Rockhampton, and C. A. E. Sheaf, Toowoomba.

DIPHTHERIA was very prevalent at Croydon, North Queensland, in the beginning of last month. Eight cases were reported in two days, three of them being fatal.

At the Croydon Police Court, on January 31, J. C. Lubinski, alias "Dr. Caesar," was fined £20 for practising as a doctor without qualification. A second charge for dispensing drugs without being registered was dismissed, the police magistrate holding that the Pharmacy Act, under which the proceedings were taken, did not provide for the offence.

DR. A. W. HAWTHORNE has resigned his position as Medical Officer to the hospital at Winton, in Northern Queensland. Applications for the vacant position must be forwarded to the Secretary, Mr. W. S. Schollick, on or before the 13th March; the salary is £350 per annum.

DR. JAS. BOOTH, a new arrival, has commenced practice at Gympie.

DR. J. J. G. MURRAY, a new arrival, has commenced practice at Maryborough.

DR. A. NICOLL, of Tambo, has declined the appointment of Surgeon to the Croydon Hospital; Dr. T. N. Flood, of Beenleigh, has been appointed in his stead.

SOUTH AUSTRALIA.

THE South Australian Board of Health has recommended to the Government that on the arrival at Port Darwin of ships from Asiatic Ports, the Asiatic passengers shall be placed in quarantine for observation, but that if the Health Officer at Port Darwin is satisfied by inspection that any of such passengers have been effectively vaccinated, in at least four places on the body, within a month of the time of the arrival, such passengers may be released from further detention unless small-pox has occurred on the ship during the voyage.

THE China steamer "Tsinan" arrived at Port Darwin with five cases of small-pox aboard.

JAMES PHILLIPS, M.R.C.S.; the Hon. Wentworth Cavenagh, J.P.; Rowland Rees, M.P.; his Worship the Mayor of Adelaide; Josiah Howell Bagster, M.P.; and Lewis Cohen, M.P., have been appointed Official Visitors to the Adelaide and Parkside Lunatic Asylums.

DR. J. A. G. HAMILTON, of Kapunda, had a rather narrow escape from a severe accident on January 11. While riding up a steep road at Bald Hill, a cow, lying in the road, got up suddenly and frightened the horse, which reared and fell back on the doctor, crushing him, underneath. He was much bruised about the chest and thigh.

DR. W. P. NESBITT has resigned his position as House Surgeon of the Adelaide Children's Hospital in consequence of the state of his health.

DR. C. W. PURVES, of Port Augusta, has been appointed Honorary Officer of Health to the Davenport local Board of Health.

TASMANIA.

DR. C. E. BARNARD, of Hobart, has been appointed Government Medical Officer; the duties attached to Dr. Barnard's appointment include those of Official Visitor Hospitals for Insane, and Chairman of that body; Health Officer for the Port of Hobart, Officer of Health for Wellington Hamlets, Medical Adviser to the Central Board of Health, Medical Attendant on Paupers at their own homes, Medical Officer for the Charitable Institution at New Town, and Medical Attendant of the Permanent Defence Force.

DR. L. S. HOLMES has settled at Moorina (Krushka's Bridge), on the upper Ringarooma River, 70 miles N.E. from Launceston.

DR. H. LAWRENCE has commenced practice at Newtown, a suburb of Hobart.

VICTORIA.

379 CASES of typhoid fever, of which 68 proved fatal, have been reported to the Central Board of Health of Victoria, from December 1, 1887, to February 2. During the same period 48 cases of diphtheria were reported, 24 proving fatal.

BRIGADE-SURGEON FULTON, who has been absent in Europe on leave, returned to Melbourne by the "Shannon," and relieved Surgeon-major Fetherston, the acting P.M.O., at the close of last month. On Thursday evening, January 19, a dinner was given at Clement's Café by members of the medical staff of the Defence Force jointly in honor of Brigade-surgeon Fulton as a "welcome home," and to Surgeon-major Fetherston on his relinquishing charge of the staff, which he has had during the absence on leave of the commanding officer.

THE election of four Medical Officers to the Melbourne Women's Hospital, Carlton, will take place about March 6; Dr. F. W. Elsner, of Richmond, is one of the candidates.

THE following gentlemen have been appointed by the Government to form "The Dental Board of Victoria," viz.:—T. M. Girdlestone, F.R.C.S., Eng., president; J. P. Ryan, M.K.Q.C.P., Irel.; T. Rowan, M.D.; G. Thomson, L.D.S.E.; L. A. Carter, D.D.S.; T. Muridge, D.D.S.; F. A. Kernot.

DR. A. MÜLLER, of Yackandandah, has informed the Central Board of Health that he has discovered an effective antidote for snake-bite in the use of strychnine.

ON February 2, a farewell dinner was tendered by members of the medical profession in Melbourne to Dr. W. H. Cutts, sen., on the occasion of his departure for Europe; Dr. Cutts has practised at West Melbourne for the last 35 years.

DR. J. W. Y. FISHBOURNE, of Moonee Ponds, has been appointed a Justice of the Peace.

DR. H. F. MAIN, late of Malmesbury, has removed to Dandenong.

DR. A. S. JOSKE has resigned his position as Resident Physician of the Alfred Hospital, Melbourne.

DR. D. S. MACCOLL, late of Bathurst (N.S.W.), has commenced practice at Hoddle-street, Richmond, a suburban city adjoining Melbourne.

DR. J. F. MATTHEWS, formerly of Rosedale, has succeeded to the practice of Dr. F. G. Hamilton at Branhholme, 240 miles W. of Melbourne.

DR. J. OLIVER, a new arrival has commenced practice at Boort, in a rich agricultural district, 176 miles N.W. of Melbourne.

DR. A. P. VAUGHAN, late Resident Medical Officer at the Adelaide Sick Children's Hospital, has succeeded to the practice of the late Dr. Dickinson at Boxhill, near Melbourne.

WESTERN AUSTRALIA.

DR. H. L. SMITH has succeeded to the practice and appointment of Dr. Rogers, at Albany; Dr. J. M. Y. Stewart has also commenced practice at Albany.

DR. F. J. ROBERTS has been appointed District Medical Officer for the Gascoyne, to reside at Carnarvon.

PUBLICATIONS RECEIVED.

Nasal Polypus, with Neuralgia, Hay Fever and Asthma in relation to Etmoiditis. By Edward Woakes, M.D., Lond., Senior Surgeon and Lecturer on Diseases of the Ear at the London Hospital; Surgeon to the London Throat Hospital. (Illustrated). London: H. K. Lewis, 1887.

Myositis Ossificans. By A. A. Lendon, M.D., Lond., Lecturer on Forensic Medicine in the University of Adelaide; with six illustrations. Reprinted from the Transactions of the first Intercolonial Medical Congress, held at Adelaide, August-September, 1887. Adelaide: Webb, Vardon, and Pritchard, 1887.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Williams, Michael Paul, M.D. & M.S. Royal Univ. Irel., 1886; L. Mid. K.Q.C.P.I., 1886.
Phillips, George Gordon Owen, L.R.C.P. Lond., 1887; L.S.A. Lond., 1886; M.R.C.S. Eng., 1887.
Wilson, Robert Archibald, M.B. Univ. Glasg., 1873; M.D. Univ. Glasg., 1876; M.S. Univ. Glasg., 1873.
Spark, John, L.S.A., Lond., 1875; M.R.C.S.E., 1876.
MacNamara, Matthew, L.K.Q.C.P. Irel., 1884; L. Mid. K.Q.C.P. Irel., 1884; L.R.C.S. Irel., 1883.
Osborne, John Henry, M.R.C.S. Eng., 1876.
Nickoll, Harvey, L.R.C.P. Edin., 1883; L.R.C.S. Edin., 1883.
Smith, George Francis, L.R.C.P. Lond., 1886; M.R.C.S. Eng., 1886.

NEW ZEALAND.

Allan, William, M.B. & Ch. M. Edin.

QUEENSLAND.

Dunlop, John James, M.B. & Ch. M. Glas., 1883.
Phillips, George Gordon Owen, M.R.C.S. Eng., L.R.C.P. Lond., 1887; L.S.A. Lond., 1886.
Booth, James.
Murray, John James Goodlate.

VICTORIA.

Oliver, John, L.R.C.P. Lond., 1886; M.R.C.S. Eng., 1886.
Maudsley, Henry, M.D. Lond., 1883; M.B.C.P. Lond., 1884; M.R.C.S. Eng., 1880.
Phillips, George Gordon Owen, L.R.C.P. Lond., 1887; M.R.C.S. Eng., 1887; L.S.A. Lond., 1886.

Additional qualifications registered:—

Grant, David, M.D. Edin., 1887.
Shuter, Charles Y., M.B. (a.e.g.) Melb., 1886.

WESTERN AUSTRALIA.

Smith, Henry Lionel, L. & L. Mid., 1886, M. 1884, K.Q.C.P. Irel.; L.R.C.S. Irel., 1884.
Stewart, John Mitchell Young, M.B. & Ch. M. Glas., 1887.

MEDICAL APPOINTMENTS.

Baird, John, M.R.C.S. Eng., to be Officer of Health for the Port of Port Fairy, Vic.
Cole, Frank Hobill, M.B. Melb., to be Assistant Resident Medical Officer, Melbourne Sick Children's Hospital, Vic.
Cox, James Wharton, M.B. & Ch. M. Ed., to be Public Vaccinator for the district of Maitland, N.Z.
Hayes, James Bennett, L.R.C.P. & R.C.S. Edin., to be Health Officer for the borough of Browns and Scarsdale, Vic.
McMahon, John, L.C.P.S. Low. Can., to be Public Vaccinator at Avoca, Vic., vice W. S. Morris, resigned.
Manson, John Frederick William, M.B. & Ch. B. Melb., to be Public Vaccinator at Malmesbury, Vic.
Matthews, James Forrester, M.R.C.S.E., to be Public Vaccinator at Branhholme, also Health Officer for shire of Portland, Vic.
Loughrey, Thomas, M.B. & Ch. B. Melb., to be Health Officer for shire of Rutherglen, Vic., vice Frank Haley, resigned.
Owens, Edward Matthews, M.R.C.S.E., L.R.C.P. Ed., of Brisbane, re-appointed Honorary Ophthalmic Surgeon to the Ipswich Hospital, Qu.
Ross, Joseph, M.D., to be Public Vaccinator at Pirramid Hill, Vic.
Sisco, Natale, M.D., to be Health Officer for shire of Ballan, Vic., vice W. S. Dobbin, resigned.
Smith, Ventry Alexander John, L.R.C.S. Irel., L.K.Q.C.P. Irel., to be Government Medical Officer and Public Vaccinator at Murrumburrah, N.S.W.
Trumpy, David, M.D., to be Public Vaccinator at Warragul, Vic.
Vaughan, Alfred Purdie, M.B. & Ch. B. Melb., to be Public Vaccinator at Box Hill, Vic.
Weld, James Charles, L.R.C.S. Irel., L.K.Q.C.P. Irel., to be Public Vaccinator at Werracknabeal, Vic., vice W. Chisholm Ross, resigned.

REPORTED MORTALITY FOR THE MONTH OF DECEMBER, 1887.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Bronchitis.	Pneumonia.
N. S. WALES.														
Sydney	135,000	243	185	94	7	2	3	...	1	16	25	11	1	5
Suburbs	200,000	726	379	248	16	7	4	...	13	67	20	18	6	10
NEW ZEALAND.														
Auckland	35,965	67	15	6	...	...	...	...	...	3	2	1	1	...
Christchurch	15,684	32	18	9	...	...	1	1	...	...	...	1	1	...
Dunedin	24,233	48	23	9	...	...	1	...	...	...	...	1	1	2
Wellington	26,966	65	19	9	...	...	1	3	...	1	3	4	...	...
QUEENSLAND.														
Brisbane	32,571	94	43	31	} ...	...	1	8	9	25	12	4	1	3
Suburbs	41,082	173	107	68										
SOUTH AUSTRALIA.														
Adelaide	311,953	780	383	199	...	...	5	4	7	62	34	20	13	21
Adelaide	42,904	108	115	49	...	...	1	...	3	16	16	5	2	...
TASMANIA.														
Hobart	31,271	85	58	22	...	...	3	...	...	8	4	6	1	1
Launceston	19,590	44	53	16	...	...	1	...	1	9	5	5	1	...
Country Districts	90,082	255	64	...	...	...	1	...	1	5	...	...	...	...
VICTORIA.														
Melbourne	69,774	150	140	} 505	15	...	3	...	15	142	87	36	14	26
Suburbs	275,606	927	777											

METEOROLOGICAL OBSERVATIONS FOR DECEMBER, 1887.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.			Depth.	Days.		
Adelaide—Lat. 34° 55' 33" S. ; Long. 138° 36' E. ....	...	98.1	72.1	48.1	29.877	...	Inches	...	...	...
Auckland—Lat. 36° 50' 1" S. ; Long. 174° 49' 2" E.	145.9	79.5	62.6	49.9	...	...	1.770	8	67	...
Brisbane—Lat. 27° 28' 3" S. ; Long. 153° 16' 15" E.	154.9	88.7	72.3	59.5	30.072	4.138	25	68	...	E.
Christchurch—Lat. 43° 32' 16" S. ; Long. 172° 38' 59" E.	153.7	79.7	57.7	37.4	...	0.987	7	70	...	...
Dunedin—Lat. 45° 52' 11" S. ; Long. 170° 31' 11" E. ....	...	...	...	...	...	...	...	...	...	...
Hobart—Lat. 42° 53' 32" S. ; Long. 147° 22' 20" E. ....	...	94.5	64.3	43.0	29.946	1.53	8	72	...	...
Launceston—Lat. 41° 30' S. ; Long. 147° 14' E. ....	...	89.5	68.3	40.8	30.010	1.06	6	66	...	...
Melbourne—Lat. 37° 49' 54" S. ; Long. 144° 58' 42" E. ....	...	94.5	66.6	46.1	29.945	5.13	13	...	...	...
Sydney—Lat. 33° 51' 41" S. ; Long. 151° 11' 49" E. ....	...	86.7	69.7	55.6	30.073	5.15	15	68	...	N.E.
Wellington—Lat. 41° 16' 25" S. ; Long. 174° 47' 25" E.	150.7	75.7	57.9	44.7	...	3.123	12	84	...	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

AN INFANT WITH TWO MOUTHS.

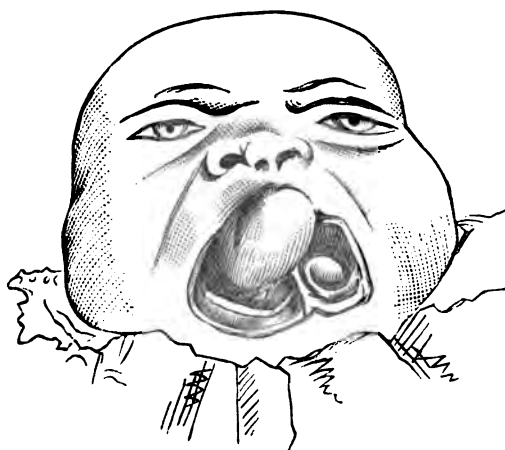
READ AT THE JANUARY MEETING OF THE
S. A. BRANCH, B.M.A.

BY ALFRED AUSTIN LONDON, M.D. LOND.,
HONORARY MEDICAL OFFICER, ADELAIDE
CHILDREN'S HOSPITAL.

THE infant was shown when only one day old at the last annual meeting of this branch of the Association, and subsequently at the late Intercolonial Medical Congress, and as the case attracted considerable attention on account of the singular nature of the deformity, I thought that it might be worth while to record a brief description of it.

The parents are healthy, and have had five other children, all of whom are living and healthy and free from any deformity; there was no suggestion of any maternal impression during the early stage of the pregnancy. Dr. O'Flaherty, of Brompton, attended the mother in her confinement, and was kind enough to send the infant up to the Adelaide Children's Hospital next day, where it was admitted under my care. He regarded it as a very unusual form of hare-lip, and this opinion was shared by those who examined it here; but more careful investigation showed that in all probability it was an attempt at twinning which had resulted in the development of a male fetus, with one head, body, and set of limbs, but with two mouth cavities, not completely shut off from one another. When the child was asleep it appeared as though it had only one mouth, much larger, however, than usual, and as though it were sucking in this mouth a large fleshy mass, covered with healthy skin, which was always suggestive of a mouthful of boiled pork too large for it to swallow. This fleshy mass was attached for about one inch to the edge of the upper lip just on the left side of the median line of the face, and was evidently formed by the fusion of the two adjacent cheeks, being marked by a faint vertical groove. From its continuity with the lip, it sloped obliquely across the mouth, being directed downwards and backwards and to the right, and its attachment extended backwards along the roof of the mouth and merged into what appeared to be a central pillar of the fauces formed by the junction of the contiguous faucial arches. Round this central pillar a bent probe could be passed, showing that both mouths opened into a common pharyngeal cavity. By approximating this central fleshy mass to a slight indentation on the

lower lip, the two separate mouths could be demonstrated very distinctly, and it was then seen that the right was much the larger in every dimension.



Faint indications, from dimpling, were seen of the separate chins and lower lips, especially when certain of the muscles of expression were called into play, but there was no well-defined sulcus between them. There was, however, a well-marked frænum, uniting the common lower lip to the jaws, or rather to the dense tissue representing the fixed gums of the adjacent inferior maxillæ, to which, at the back, the central pillar of the fauces was attached. This tissue was so tough that no movement was obtained between the two lower jaws. On the right side the uvula was normal, though displaced rather to the outer side, in the left mouth the palate was cleft. The alveolar processes of both jaws in both mouths could be completely traced, but in places they were greatly distorted, as on the right side of the left lower jaw. The width between the rami on the left side was about half the width on the right side. The upper maxillæ were more difficult to trace out, owing to the projection of the central cheeks.

The right tongue was visible in its mouth, which was too narrow to allow of its lying flat in it, consequently it was arched transversely, and looked thicker than natural. This was even more marked in the left tongue, which was much smaller, and did not reach to the front of the mouth, being out of sight when at rest.

The nose, as a whole, was large and wide, and the columella inordinately thick. At the junction of the columella with the lip a third central nostril was seen, large enough to admit a probe,

which, however, could not be passed into it for any distance.

One would have expected two distinct hyoid bones, but they could not be demonstrated. The larynx and trachea were either very wide, or else double, and it was thought that a groove dividing two tracheæ could be felt.

The baby was kept in the hospital for three months, during which time it nearly succumbed to thrush. It was fed with a bottle, which it could suck with either mouth. At first it wasted very much, but after a time improved, and was then sent out, and shortly after its discharge it died of inanition. Had it lived and thrived I had intended to have performed a plastic operation, to have included obliteration of the central nostril, and removal of the central cheek mass. Unfortunately the child was not brought to me after its discharge from the hospital, otherwise our museum might have been enriched with a very unique specimen of monstrosity. It must remain a matter for conjecture as to whether, if it had lived, it would have resembled the "Two-headed Nightingale," in being able to sing duets.

THE USE AND ABUSE OF ANTISEPTIC IRRIGATIONS IN MIDWIFERY PRACTICE.

BY GEO. REGINALD EAKINS, M.D., CH.D.,
BRUX., L.R.C.P. AND L.R.C.S., EDIN., ETC.,
ECHUCA (VICTORIA).

I HAD written a contribution for the *Australasian Medical Gazette*, under the heading of Hints in Midwifery Practice and Management of Puerperal Cases, which I had not forwarded in time for insertion in last month's number, but seeing that I was somewhat anticipated by Dr. Elsner on the same subject, I have thought well to re-write my article, and place it under the above heading.

I have within the last four years conducted two hundred and sixty midwifery cases, including premature labors and abortions, amongst my private patients, with only one death. In thirteen of these I have resorted to intra-uterine irrigations, viz., six at full time, four prematurely confined, and three abortions on account of sudden cessation of lochial discharges and high temperature, &c. The intra-uterine injections I considered absolutely necessary in each of these thirteen cases.

Strange to say, I had thought that plain warm water would do as advised in Dr. Elsner's article,

but was disappointed with the result, as the temperature never fell as well as when I used antiseptic injections. After various experiments, I found that warm water, as hot as I could keep my elbow in, tinctured with the B.P. solution of permanganate of potash (four grains to an ounce) of which I used an ounce to an ordinary hand basin three parts full, was the best. I had experimented with solution of corrosive sublimate, one in two thousand, and carbolic acid one in one hundred and fifty or two hundred, and I found that they gave pain and were unsatisfactory, and did not get rid of the factor like the Condy solution. I have had to use these intra-uterine injections as often as four times in the twenty-four hours, besides vaginal injections by the nurse two or three times daily at same time. I have, to my own mind at least, proved conclusively the extreme value of intra-uterine irrigation in the puerperal patient, as opposed to vaginal injections. In the very last case I attended a leading consulting practitioner was called in consultation, and advised vaginal injections merely, as he said that uterine kept up irritation, besides the danger of regurgitation and distension of the fallopian tubes. I acted on his advice with the result that the temperature never fell after the injections, although it always fell both previous to consultation and after I resumed the intra-uterine irrigation. I may mention that the vaginal temperature was 108° in this case, with a reading of 106° in the axilla. I have found that after uterine injections in these cases the temperature fell from 106° to 102° and 103° within an hour. Whilst on the subject of uterine irrigation I may mention that whenever, through an accident, as the end of syringe slipping out of the fluid in basin, a little air entered, or rather, was injected, the patient complained of pain, which sometimes lasted for a couple of hours, and I found that in spite of all my precautions a little air always did enter whenever I used the Ingram's india-rubber enema syringe. I have, however, for a considerable time used what is known as the Alpha syringe, manufactured by a firm in Philadelphia, which, entirely, with ordinary care, obviates this difficulty, as the stream is continuous, not intermittent. I always inject slowly, allowing plenty of time for the fluid to return, and, an important point, I never allow any person but myself to administer these injections, and with them I have experienced the best and happiest results. I deny the possibility of fluid entering the fallopian tubes when the injections are carefully made in suitable cases, and think the danger more than problematical, especially when we consider in these cases that we have the pelvic viscera in a state of congestion, with more or less peritonitis, and

occluding the fallopian tubes. I will swear positively, after extended use in the old country, and here for the past four years, it has never occurred in my hands. I think the position of the patient when the injections are being given has much to do with their success. I always place my patient on her left side, with the buttocks overhanging the edge of the bed, and with the body parallel with the foot of the bed, in other words the woman lies perfectly athwart the bed. I then insert the forefinger of the left hand into or against the cervix, and guide the warm softened and bent vaginal tube into the cervix right up to the fundus with the right hand, if this is done, and a piece of mackintosh cloth placed so under the patient that the fluid may run into a vessel put in position by the side of the bed to receive it, the injection by the Alpha syringe will neither hurt, prove irksome, or in any way discommode the patient. I continue the injection until the fluid returns quite clear, and in nowise discoloured.

As to drugs, in treatment I have discarded all (including the antipyretics, salicine, quinine, antipyrin, &c.), in favor of *opium*, which I give from the onset of puerperal symptoms, and continue right through until the temperature is again normal. I order the gum *opii* itself, made into one grain pills, of which I administer one every single hour, or every two, three, or four hours, according to the urgency of the case. No matter what state the tongue is in I give my *opium*. If the bowels are too confined I administer about six or eight ounces of salad oil, which injection is for a time retained, but if after 24 hours it should prove unsuccessful, I administer a warm soap-suds enema, as much as can be comfortably borne (about two pints). I always give brandy at the same time in tablespoonful doses every three or four hours, well diluted in plain or iced water, also egg flip, concentrated meat essences, milk, plain or peptonized, and allow plenty of cold water as a drink, and with good intelligent nursing I solemnly declare I have not so much dread of this *bête noir* of the general practitioner. The treatment, to be successful, must be begun early.

I live in a portion of the colony in which the weather is very hot in summer time, and I always endeavour to get my patients to consent to be confined on a new clean straw bed, that is, a tick filled with straw, if not cut up fine, beaten with a stick, until it is quite soft, which, indeed, makes a very healthy and comfortable bed. I mention this because the beds and mattresses bought at sales and auction rooms may have had patients previously lying with infectious diseases on them, and in which may exist the germs to start a case of puerperal fever in the ignorant woman, wholly unconscious

of danger from such sources. "Flock" beds I have a perfect horror of, being for the most part made of undisinfected rags, gathered anywhere, and tattered to shreds, and indiscriminately bought or exchanged amongst poor people.

To make vaginal examination I never use anything but carbolyzed vaseline, half a drachm to the ounce, to smear the fingers with. I carry this in a small wide-mouthed bottle, protected by a boxwood case, with a cover to screw on in my midwifery bag. I used to use Richardson's thymol jelly, which is put in compressible metallic tubes, and very handy, but I found in this district that the heat melted the vaseline, and left the thymol in crystals, which, if used, irritated the vaginal cul de sac.

I never examine my patient at the beginning of labor, unless she is placed athwart the bed, lying on her left side, and then with the index or index and middle finger of my *left* hand. By this means you at once bring the soft sensitive pad of fingers against the upper portions of vaginal wall, which enables you to immediately make out state of cervix, presentation, &c., and without in the least hurting your patient, besides saving the necessity of making a second examination, which may, perhaps, hurt the feelings, if nothing else, of a sensitive woman, an item in practice not to be despised.

I never now support the perineum, as I found it do more harm than good. When the labor is completed I order the nurse or attendant to bathe the genitals and perineum with warm water in which has been placed some Condyl's fluid. For this purpose I carry permanganate of potash crystals in my bag. I very rarely have to use sutures, and if I did, I should use sutures of silver wire, being undoubtedly the best, because, unless torn considerably, what may appear a big rent at the time will, in a few days, become insignificant, as the stretched tissue resumes its normal size.

I would as soon think of blood-letting, as of giving my patient an intra-uterine injection, unless chills, or rigors, suppression of milk and lochia, with high temperature, had supervened, and I agree in deprecating with Dr. Elsner, the highly pernicious and altogether unnecessary routine treatment of ordinary cases by uterine irrigation, but must deferentially record my opinion that I do not believe hot water alone antiseptic, at all events at the temperature that can be used, and that I have experimentally proved the weak solution of permanganate of potash to be the safest.

If my paper is rather rambling I have hurriedly tried to submit what few facts I have practically become possessed of, and found valuable to the

general practitioner and accoucheur, and hope that, although I cannot say I have added anything very new to the literature of the subject, my hints will, I believe, be found useful to the many young practitioners like myself who are scattered over the colonies, and I thought it necessary to diverge from the subject of uterine irrigation to record the few facts and hints I have found myself so useful in making a reputation as a successful obstetrician.

URÆMIA.

READ BEFORE THE N. S. WALES BRANCH, B. M. A.

BY T. M. KENDALL, L.R.C.P. *et* R.C.S. EDIN.

THE subject of Uræmia is so full of matter worthy of discussion, and so interesting, both on account of its connection with chronic renal disease, and with certain interesting phenomena occurring in pregnancy, that although I knew I was unable to set before you any new facts, I thought I might venture to introduce it to you this evening with hope of provoking a useful discussion.

Definition.—Professor Grainger Stewart applies the term uræmia to that group of nervous symptoms which occasionally occur in the course of acute or chronic Bright's disease, as well as in other maladies which prevent the secretion or the discharge of urine.

He is most particular in impressing the fact that any disease of the kidneys which interferes with the secretion or discharge of the urine may call uræmia into existence, and that very many persons afflicted with Bright's disease pass through life without any sign of uræmia, although they are of course predisposed to the same.

Uræmic attacks are very frequently precipitated by pregnancy, parturition, and indulgence in alcohol. Many women, however, who suffer from Bright's disease may become pregnant and are safely delivered without any appearance of uræmia.

Dickinson holds that the term uræmia implies nothing more specific than that the blood is altered by the presence of materials which, in their own shape, or under some other guise, ought to have passed out of the body by the kidneys. Lusk again says it is the action, not of a single constituent of the urine, but of all the excrementitious principles, combined with that of arterial tension.

The fact that the symptoms of uræmia are often like those of narcotic poisoning, seems to point to a change in the fluid, and not in the solid portion of the body. Uræmia is common in cases of infectious fever, and is due to suppression of urine.

Dr. Gee states that uræmic convulsions are rare in scarlatina, and when present are always fatal.

The *phenomena* of uræmia affect both the nervous and muscular systems.

They consist of convulsions of the voluntary muscles, headache, drowsiness, defects of sight and hearing, and vomiting. Delirium is rare, while coma is frequent. Convulsions also often occur, but we rarely find paralysis.

Headache is the most common of all uræmic symptoms.

Loss of sight is usually temporary and not due to any organic change in the eye. It is in fact a purely cerebral phenomenon. It is not due to that retinitis which is not uncommon in Bright's disease.

The Convulsions are of an epileptiform character, and the symptoms are not at all unlike those of epilepsy, viz, insensibility, rolling of the eyes, biting of the tongue, and foaming at the mouth.

Vomiting is perhaps due to a vicarious elimination of urea by the gastric mucous membrane.

Coma usually follows the convulsions, although it may precede them.

After paroxysms of both coma and convulsions the patient may regain consciousness, and years may possibly pass before another attack takes place.

Uræmia may possibly, more especially when it has reached the state of coma, be mistaken for *apoplexy* or *narcotic poisoning*, and, during the convulsive stage, for *epilepsy*.

From *apoplexy* it may be distinguished by the absence of paralysis.

From *narcotic poisoning*, by the dilated state of the pupils.

From *epilepsy* the diagnosis is somewhat difficult, but usually the antecedent history clears away the doubt.

All cases of uræmia do not exhibit the whole of its phenomena. In some we have a single phenomenon present, and in others, several. It is, therefore, perfectly possible that cases which may have been due to uræmia have not, on account of the slight characteristics they have possessed, been correctly diagnosed. By this I do not mean to say that we are always to be on the look out for uræmia, but that when we have present a persistent symptom such as headache, it may possibly be due to uræmia although we have not connected it with such a cause. I think this is a point of greater interest when we consider the extent to which alcoholic drinking is indulged in these colonies, and how prone the kidneys are to become affected by the abuse of stimulants.

The following two cases which I have had lately under my care will serve as illustrations of one, at least, of the phenomena of uræmia. I much

regret that I am unable to bring before you any number of other illustrations :—

I. Last month a girl, aged 14 years, came under my care. She had for the past eighteen months been troubled with a persistent sense of weight in the head, which had not in any way yielded to the usual remedies for stomachic ailments. When I first saw her she was much puffed over the whole surface of the body, and had a persistent pain in the head; her urine was bloody, scanty in quantity, and loaded with albumen. She was very frequently attacked with vomiting; her bowels were well open. I treated her with Simpson's hot-air bath, large doses of digitalis and pot. bromide, and a good allowance of distilled water. This patient made a good recovery from what I considered as an attack of uræmia following a scarlatina two years previous.

II. A lady, pregnant about six months, was suddenly attacked with an intolerable headache, for which she had unlimited treatment without any result. When she came under my care she was in great agony and was very prostrate from want of sleep. Her urine was scanty and contained a third of albumen; her bowels were sluggish. I unloaded the bowels and prescribed rest and sedative mixtures, but was unable to give her much ease. Large doses of urethane procured her sleep, but when the effect of the drug wore off the intolerable pain returned. In three days she aborted and afterwards made a good recovery, although the headache persisted for some time.

This case also I consider to be uræmic, and serves as an illustration of one of the principal phenomena (headache) of the disease. The headache, so persistent before, yielded as soon as the uterus was emptied of its contents. The cause of the uræmia was probably due in some measure to the pregnant state, for I had been consulted by this patient before she married and she was not then suffering with Bright's disease. I will not, however, raise this question, as it will arise again towards the end of this paper. I merely relate the case here as illustrating headache, one of the phenomena of uræmia.

The *pathology* of uræmia is somewhat veiled with doubt, for as the theories are various there are many followers of and believers in each. Some writers pretend to distinguish between two forms of uræmia (cerebral and toxæmic), but as the signs and symptoms in each of these forms are altogether similar, there are not many who believe with those who put forth this idea.

In considering this matter it is useful to note that there are different opinions as to whether urea is formed in the blood or in the kidney. Grehant (*Archives de Physiologie*) has shown that urea is formed quite as rapidly when the kidneys are

removed as when they are intact. Cyon has demonstrated that the excretion of urea by the kidneys is diminished in cases of hepatic disease, and that there is a larger proportion of urea in the blood before it enters the liver. Dickinson also is of opinion that urea is of extra-renal origin.

It is possible, therefore, that when the excretion through the kidney is interfered with, as in albuminuria, urea may accumulate in the blood and be the cause of all those nervous phenomena to which the name uræmia is given.

Traube and Rosenstein consider that convulsions in uræmia are due to acute cerebral anæmia, brought about by pressure on the minute vessels of the brain through a serous effusion into the cerebral tissues, the result of a peculiar hydræmic condition of the blood. Accompanying this is an increased tension of the arterial system and hypertrophy of the heart. The presence of albumen merely accelerates the anæmia.

Now, as anæmia of the brain is a common cause of convulsions, the reasoning of Traube and Rosenstein would therefore appear to have a good basis; but *post-mortem* examinations conducted by Löblein and others have shown a complete absence of œdema, or anæmia of the brain, or flattening of the convolutions. Frerichs, who is supported by Lehmann, believes that toxæmia is the true factor of the evil, for when albuminuria exists the urine contains less than its normal quantity of urea, while the blood has it in excess; convulsions, therefore, are due to the influence of uræmic poisoning on the central nervous system. Frerichs supposes also that it is not urea, but its decomposition into carbonate of ammonia in the blood which causes convulsions, and he has made experiments through which he found that the injection of carbonate of ammonia into the veins produced convulsions. This last theory is completely controverted by Hammond, of Virginia, who made a series of careful observations with a contrary result to Frerichs.

Although there is very much to be said in favour of the theory of anæmia as the cause of uræmic convulsions, there is every reason to believe that some change taking place in the blood—such as an accumulation of excrementitious matter, causing an irritation of the nervous centres—originates the uræmic state. Macdonald believes that the vasomotor centre is irritated, and produces anæmia of the deep nervous centres.

Whatever explanation we may at present accept of those very interesting phenomena called uræmia, we can only suppose it to be the correct one. Some day more light may be thrown upon the subject, and a better explanation may be given. Till then we are bound to accept that theory which appears the most sound, viz., the theory of toxæmia.

The treatment of uræmia points to two ends, viz. :—lessening of the cerebral irritation, and the removal of the accumulated poison.

Venesection has very many strong supporters, and without doubt in those cases where the symptoms point to increased cerebral vascularity, should be practised; but it is important to remember that anæmia of the brain is a cause of convulsions, and therefore that injudicious venesection will tend to increase rather than diminish one of the grave evils with which we have to contend.

Supposing also that we do accept the theory of anæmia, we cannot accept of the practice of venesection which increases this state. Dr. Fordyce Barker is one of the greatest supporters of venesection, and in his hands the practice of it has proved successful. Trousseau recommends compression of the carotids, so that by cutting off the supply of blood the cerebral symptoms shall be diminished. I have myself found this practice useful in some forms of convulsions, especially those occurring during the period of dentition in children.

The administration of chloroform successfully controls muscular actions of the convulsions, and without doubt places the patient in the greatest state of comfort. It moreover relieves the practitioner of immediate anxiety, and allows him to arrange the details of further treatment. Against this most valuable aid it has been urged that it causes cerebral congestion, for it lessens arterial tension and controls muscular action, thus increasing hyperæmia. Be this as it may, record shows that its administration, as a rule, has been followed by success. A theory that chloroform is useful by checking the decomposition of urea into carbonate of ammonia in the blood has been suggested, because it promotes the formation of sugar, and sugar prevents the decomposition of urea.

As soon as we have coped with the more immediate symptoms it becomes necessary for us to lay down some settled plan of after-treatment, the end which we hope to attain by such treatment being to restore as soon as possible the action of the kidneys.

Free purgation by jalap, elaterium or croton oil; the careful exhibition of diuretics, especially digitalis and distilled water; and hot-air vapour baths, are our sheet anchors, for by this practice we will not only eliminate the poison from the system, but also bring back, as far as lies in our power, a normal renal action. Such is all I propose to say concerning uræmia generally. I now wish, briefly, to engage your attention with the subject of puerperal convulsions, concerning the origin of which there are many conflicting opinions.

Our knowledge concerning the true pathology

of puerperal convulsions is not at all clear. Many good authorities assert that the presence of albumen in the urine is the principal factor; but there are others who deny its importance, and say that unnecessary stress has been laid upon it. Whichever statement may be true, it is worthy of remark that albumen is usually detected in the urine either before or after the onset of the convulsions.

In 1843 Lever showed that the urine in cases of puerperal eclampsia was generally highly charged with albumen; and he stated that having regard to the fact that similar convulsions were sometimes associated with cases of chronic Bright's disease, he concluded that puerperal eclampsia was due to toxæmia, resulting from the excess of urea in the blood. In this theory he was supported by Braun and Frerichs, although later on Frerichs propounded his theory of the decomposition of urea into carbonate of ammonia, which theory has been controverted by Hammond, of Virginia.

Imbert, Goubeyre, and Blot state that the greater number of cases of albuminuria are not accompanied by convulsions, and that cases have been observed where the albumen became present after the convulsions and was probably due to the same inducing cause. Braxton Hicks has recorded a number of such cases, and finds that the onset of the convulsions and the appearance of albumen are simultaneous.

Spasm of the glottis during the convulsion inducing a high state of venous congestion, and thus producing kidney mischief, has also been given a place among the accredited causes of albuminuria.

Tyler Smith says that the liability of pregnant women to convulsive attacks is due to the peculiar excitable condition of the nervous system during pregnancy, and that toxæmia or anæmia is the exciting cause.

Kussmaul and Tenner support Traube and Rosenstein's anæmia theory, and add—"The occurrence of labour intensifies the attack, since during the acme of the pains the tension of the cerebral arterial system is necessarily greatly increased."

Frankenhauser, of Jena, has made a series of delicate dissections which demonstrate a direct connection between the nerves of the uterus and the renal ganglia. He, therefore, is of opinion that the albuminuria depends on irritation of the renal ganglia through their connection with the uterine nerves.

This theory of Frankenhauser has been somewhat anticipated by Tyler Smith, who suggested that the formation of albumen might be due to sympathetic irritation of the kidneys by the gravid uterus.

Should Frankenhauser's dissections be confirmed by the researches of others, very much of what is at present inexplicable concerning the relation of albuminuria to puerperal eclampsia will be made clear.

The primary cause of puerperal convulsions is evidently some blood change, either an excess of its watery composition, or the accumulation in it of some toxic principle. The balance of opinion is in favour of toxæmia, although opinions are somewhat divided as to the connection between it and albuminuria.

It is, however, fair to assume that renal insufficiency is the principal cause of the toxæmia and also of the albuminuria. In fact we may very aptly quote the words of Lusk, who says—"In the vast majority of cases we are brought face to face with the very striking coincidence between renal insufficiency and the convulsive seizures. This insufficiency may or may not be associated with albuminuria, though the two go pretty constantly together."

Unnecessary stress is often laid upon the presence or absence of albuminuria in the urinary secretions. It is the renal insufficiency that should be fixed in the mind, and not the albuminuria as the cause of uræmia and convulsions. It is not reasonable, because in very few exceptional cases uræmia is absent in puerperal eclampsia, to deny to uræmia, in the overwhelming proportion in which it is present, its importance as the most distinctive factor. Uræmia is the fountain and origin of the evil.

In speaking of the treatment of uræmia, or more properly puerperal convulsions, I shall confine myself to that portion which deals with the expediency of interfering with the natural process of parturition.

First I would draw your attention to a case which I recently had under my care. I will not weary you by detailing symptoms or after-treatment in this case, but put before you as briefly as possible that line of treatment which I adopted with regard to the uterus and its contents. In this case I was associated with Dr. Scot-Skirving, who rendered me much valuable assistance. On the morning of May 31, 1887, I was called to a woman in a state of puerperal convulsions. She had been passing bloody albuminous urine in scanty quantity, and had a history of renal mischief. She was seven months pregnant with her first child, and although the convulsions were strong there was not any sign of labour. On examining *per vaginam* I found the cervix stretched over the head, with os tightly closed. Hoping to abate the violence of the attacks I administered chloroform, but I found that unless the patient was kept well under its

influence the attacks returned with greater violence. I then determined to induce labour with a view of at least removing one cause of irritation. Dr. Scot-Skirving kindly came to my assistance, and kept the patient under the influence of the anæsthetic. Carefully introducing my finger into the cervix I gradually dilated it so as to admit a Barnes' bag, and dilating again got in my four fingers. Finding the internal os rigid I incised it with a bistoury. I then perforated the skull and crushed it so as to diminish its bulk. Having removed a portion of the vault of the skull, and having broken up the base, a pair of Lion forceps was passed in and made to seize the remnant of the head. The foetus was then pulled down and delivery completed.

This patient had no bad symptoms afterwards, and the convulsions did not return. She is now able to get about and experiences no inconvenience; her urine is still albuminous.

Opinions differ greatly as regards the course of treatment pursued in the foregoing case, and although I am in every particular supported by the authority of Meadows, who advises in such cases when labour is not advancing, gradual dilation of the cervix, incision of an unyielding internal os, and that delivery can only be quickly effected by resorting to craniotomy, still other good authorities hold a contrary opinion.

Gooch prefers to control the convulsive movements and leave the labour to nature. Schroeder is unwilling to interfere unless the convulsions greatly increase in severity. Tyler Smith says—"If there is reason to suppose that the operation necessary to complete delivery is likely *per se* to prove a greater source of irritation than leaving the case to nature, we should not interfere." Fordyce Barker is inclined to agree with mechanical interference; and Lusk says that—"The practice of waiting on nature is uniformly disastrous, while the resort to art furnishes you with a fair measure of success."

For myself I must say that unless labour was progressing very easily, and delivery was likely to be effected rapidly, I shall always deem it my duty to expedite matters, for I believe that when the uterus is emptied one great source of irritation is removed, and other treatment can be carried out more effectively.

Gentlemen, I trust I have not wearied you by the length of this paper, and also that I have made my meaning clear, viz., that uræmia is due to the persistence of excrementitious matters of the urine in the blood; and further, that the convulsions occurring during pregnancy and parturition, more commonly called puerperal convulsions, are similar to those occurring in chronic Bright's disease, and are induced by the same cause—uræmia.

CASE OF GUNSHOT WOUND THROUGH THE LUNG.—RECOVERY.

By W. A. LIGHTBOURNE, M.B.,
HAWERA, NEW ZEALAND.

A. A., aged 25, was arrested while getting out of the train, about 12 a.m. on the 28th January, last. He asked the arresting constable if he might go into the urinal for a minute as he wanted to micturate. He carried a Colt's revolver concealed in the inside pocket of his coat. The moment he got behind the curve of the door he put his hand in his pocket and discharged the contents of one barrel into his chest. He was seized by the constable before he had time to discharge any of the other barrels. The constable and another led him by the arms to the nearest hotel, about 100 yards distant. At first he managed to walk steadily, but before he got half way he felt inclined to fall, and it was with difficulty that he was got to the hotel. I was immediately sent for and arrived in about 15 minutes.

I found him suffering severely from shock, and almost in a state of complete syncope. His pulse was barely perceptible at the wrist, his heart was beating very slowly, his face was ashy white, his extremities were cold, and he was bathed with a cold and clammy perspiration. Had his clothes removed and found a gun shot wound about two inches below the left nipple. Used a bullet probe to find the direction of the missile, and found it to have gone straight in, penetrating the lung.

He was so prostrated that I could examine no further just then, as I was afraid of immediate and fatal collapse. I gave him a glass of brandy and had warm bottles applied to the extremities, and sent off to the chemist for spt. Am. ar. The brandy did not seem to rally him in the least, so I gave him 20 minim doses of the spt. Am. ar. in water every 20 minutes, till the pulse began to rally, after that at longer intervals. I continued applying the hot bottles, having fresh ones applied every half-hour, they were as hot as they could possibly be borne. All this time the wound was bleeding slightly. In about two hours I was rewarded by finding the pulse considerably stronger, a nice colour returning to his face, and his extremities were growing slightly warmer. I now was able to turn the patient slightly, and found that the bullet had not passed through, and on a closer examination found it resting between the ribs in a direct line with its aperture of entry. He was still too weak to have the ball removed, so I determined to wait till he had sufficiently rallied, which happened in about four hours more, or exactly six hours from the time of his shooting himself. At 8 p.m., in company with Dr. Chilton, of this town, I proceeded to remove the ball. The

operation was very simple, the ball was easily secured and removed, the patient bearing the operation very well. After the operation there was a slight loss of blood from the wound in the back, especially when he coughed. I forgot to say that the cough was at first very harassing, and was accompanied by a very copious bloody sputa, but after the wound in the back was made the cough gradually ceased. Also, the bloody sputa, and what slight bleeding there was, was through the wound in the back. At 10 p.m. the thermometer showed the temperature to be 97°. The patient expressed himself as much relieved, said he could breathe easier, and complained of little or no pain. His countenance was still very anxious. Continued the spt. Am. co. and brandy, and gave his nurses instructions to keep him as quiet as possible, and allow no one to talk to him. Saw him again about 2 a.m., found the temperature had risen to 100°, not so anxious an expression, breathing easier, cough much less troublesome, and the bleeding from the wound had now almost entirely ceased. Ordered a lotion of carbolic acid and glycerine, one in 30, to be applied to the wounds. 29th, 8 a.m., colour good, breathing much relieved, temperature 102°, but very thirsty. Ordered a slight effervescent, and that his food should be given him not hotter than the temperature of milk as it comes from the cow; continued the dressing as before; ordering the rest to be absolute. 3 p.m. same day, patient doing well, but there was a very fetid breath, as from decomposing blood in the stomach and lungs, I thought it possible that he had swallowed some blood, and as he complained of feeling very sick I gave him an alternative. After the lapse of five hours he had a motion containing a considerable amount of blood, the second motion three hours after the first was natural, the smell had now ceased, and the patient continued to do well.

On the eleventh day there was slight secondary hæmorrhage, but by the application of cold to the chest it soon ceased, and the 18th of February, or 17 days from shooting himself, the patient had so far recovered that he was able to be removed to Wanganui, a distance of slightly over 60 miles from here.

On examining the ball it was found to have struck some hard substance, as one side was completely curved, and the ball, in passing through, made a complete turn, as the point of the ball looked inwards instead of outwards, and the forceps seized the thick end and not the small end, as would have been expected, showing plainly that the dent on the ball was owing to having struck the rib, and doing so it caused the ball to turn on itself.

A CASE OF PORRO'S OPERATION FOR RACHITIS OF PELVIS.

By H. C. GARDE, F.R.C.S., ED. (BY EXAM.),
SURGEON TO THE MARYBOROUGH HOSPITAL,
QUEENSLAND.

Mrs. C., aged twenty-three, was brought under my notice about three weeks before her admission into hospital. She was then within a month of her full time of pregnancy. Owing to her dwarfish appearance, coupled with the statement of her mother (Mrs. M.) that the father's branch of the family suffered from rickets, I made a careful examination, and found that the antero-posterior diameter of the pelvis was only one inch and a half. I at once informed them of the fact that a living child could not be delivered *per vias naturales*. Her aunt on the father's side had had craniotomy performed six times, and died in the last confinement, so that when I laid the different operations before her, one of which it was necessary to have done, she decided on having the above-named one, her mother was anxious for her to do so, seeing that probably if she survived caniotomy, a repetition was likely to happen again, and in the end terminate like her aunt's.

Her general health being good, and due attention having been paid to the state of her bowels, she was admitted into one of the private wards on the 7th of January, 1888. On the morning of the 8th, after a very light breakfast, early in the morning, she had an enema of warm water, chloroform was administered to her in bed, she was then carried into the next room, and at half-past 10 was placed upon the operation table. I made an incision of about five inches, extending from the umbilicus to the pubes, there was little or no hæmorrhage, so that we were able to dispense with the pressure forceps. On opening the peritoneum to the full extent of the external wound, carbolised sponges were carefully packed around the edges, then an incision, a little over an inch, was made through the uterine wall, when I introduced both my index fingers, and tore it boldly open, to the extent of five or six inches, as recommended by J. Knowsley Thornton. Next slit up the membranes, and extracted the child without difficulty. The neck of the uterus was at once grasped, and the wire of a Braxton Hicks' wire ecraseur passed around it, including both the tubes and ovaries, it was then tightened up, and

the whole mass cut off, the placenta remaining *in situ*; but little bleeding took place. Not having proper pins, the needles of an aspirator were used as a substitute to fix the stump. Four deep sutures were next passed, and after the peritoneum was carefully sutured to the base of the stump, they were drawn together and a few superficial ones inserted. Iodoform was liberally dusted over the surface of the stump and wound, a pad of absorbent cotton placed over it, broad strips of isinglass plaster, with a light flannel bandage were used to support the abdominal walls (all the sutures used were of silk). Six hours afterwards some oozing took place from the stump, for which a stout silk ligature was applied, and the surface touched lightly with the thermo-cautery. In four hours bleeding again took place, when an elastic ligature (small drainage tube) was passed twice around the stump, superficial to the pins, and securely tied, after that no more trouble was experienced. Nothing but ice was allowed for the first thirty hours, as she had considerable retching, followed by iced soda water and milk, beef tea, &c. The catheter was used every five hours until the third day, when she passed urine naturally. The temperature only once went up to 101.6, and that was on the 21st of January, two days before the stump separated. Some of the sutures were removed on the fifth day, and the remainder on the seventh, when the wound was for the greater part healed. She was able to be moved on to the sofa on January 26th, on the 29th she walked about the room, and since then walks out on the verandah daily, until now (February 4th) only a small depression remains at the site of the stump. The child (a son) is being brought up on cow's milk.

Remarks.—The aspirator needles were only a makeshift, and were hardly long enough, the pins ought to be six or seven inches, with flat heads like hare-lip ones, but stronger. Not being able to obtain a Kœberlé's *serre-nœud* I had to use the ecraseur, and think that it slipped, or else the wire used was too fine, and that was the cause of the oozing from the stump. The elastic ligature with the pins would, I believe, be quite sufficient. Although an operation for the removal of the uterus for fibroid was done by Dr. J. Foreman in Sydney in 1886, as far as I can ascertain, this is the first Porro's operation performed in Australia, and, as such, it may be as well to place it on record. Dr. Hall kindly administered the anæsthetic, and I was ably assisted by Drs. Bowe and Murray.

[A Porro's operation was performed successfully by the late G. Fortescue, M.B., in the Prince Alfred Hospital, and it was reported in the May number of the *A.M.G.* in 1884.—ED. *A.M.G.*]

NOTES ON FOUR CASES OF DISLOCATION OF THE LENS—TWO TRAUMATIC, TWO IDIOPATHIC.

READ BEFORE THE QUEENSLAND MEDICAL SOCIETY ON JANUARY 10, 1888,

BY E. M. OWENS, HON. OPHTHALMIC SURGEON
BRISBANE CHILDREN'S, IPSWICH, AND TOO-
WOOMBA HOSPITALS.

WM. MCN., *æt.* 38, was first seen by me on July 6 of last year. The history was that a few days previously he received a blow from a chip of wood on the left eye, which was very painful, but he worked on applying cold water to it. I found the eye was very much congested, and rather painful, the iris (which was partially dilated) was tremulous in the outer half, and by ophthalmoscope I found lens was dislocated from its outer attachment, being turned backwards and inwards into posterior chamber. I was in some doubt as to what would be the best treatment. If I attempted extraction I should have to dilate, and might lose too much vitreous, if I needled I should perhaps pull too much on ciliary region, and set up cyclitis. I decided to leave it alone for a short time until the lens became more opaque, keeping the eye carefully bandaged, and applying a few leeches to the temple. This treatment soon allayed all irritation, and after a few days I was able to push the lens further backwards and inwards, in fact, doing a partial conchi operation. For after-treatment I kept the eye bandaged and used Eserine. This was fairly successful, as by means of + 3½ D he can see $\frac{3}{8}$ —. I intend shortly, when I feel sure that the lens is quite hard, to attempt extraction by means of scoop.

J. C., *æt.* 84, dislocation of lens, through lacerated wound in sclerotic. I am indebted to Dr. Thornton, of Ipswich, for this case. The history was, on December 16 he was thrown from his horse, and found insensible, with, among other wounds, extensive laceration in the neighbourhood of the temple. Dr. Thornton thought there was fracture of some of the orbital bones, but the swelling was so great that diagnosis was not quite clear. The eyelids were much swollen, and on getting them opened it was seen that the anterior chamber had some blood in it, and that there

was a swelling in the conjunctiva at the upper part of the eye. As it was doubtful what it might be, he was brought to me for consultation on December 30. I recognised that it was the lens which had been dislocated, through a laceration in the sclerotic, and lay under the conjunctiva, forming a round swelling on the eye under the upper eyelid. I removed it without difficulty, under cocaine, and the rent in sclerotic could be seen situated about 2 m. m. on sclerotic side of the corneo-scleral junction. I examined him again on January 10, he had perception of objects passing between him and the light, but I could not get a clear view of fundus to examine what mischief had been done to choroid and retina.

Miss McL., *æt.* 13, was first seen by me on January 7. Three years ago had fever, when getting better, suddenly became totally blind for eight or nine days, but vision gradually returned to a certain degree, but has never had the same sight since. Present condition.—Is a thin, delicate girl, comes into the room with a halting gait, not from deficiency of vision, but from some spinal trouble. On examining eyes found vision for distance was $\frac{1}{2}$, but could read .08 at four inches. The iris was moderately dilated, and was tremulous in both eyes, which made me think I had a double dislocation, and on dilating I found it was so, the dislocation was quite symmetrical, the lens lying to the inner side in both eyes, + glasses helped her somewhat. I recommended nothing to be done.

Mrs. McL., *æt.* 40, a healthy woman, mother of former girl. Said "she did not come about herself, but her daughter, she herself had been blind in one eye for 17 years," also came on after an illness. Unless looked at closely there was nothing noticeable about her eye, but on carefully examining it was seen that iris was tremulous, and the aqueous fluid could be seen (if I may use such a term) splashing about ant. channel at every movement of eyeball. On dilating pupil no trace of lens could be seen, but the shrivelled up capsule lay at the lower edge of pupil. The whole of the corneal substance having been absorbed.

REMARKS.—To have seen these four cases, almost at the same time, and be able to show three of them in a group is both interesting and instructive. I hardly think we can look upon the two idiopathic cases as one being hereditary from the other, I think that it was but a coincidence that mother and daughter should be afflicted with the same disease. J. C. must have fallen upon a small stump, giving a direct blow under the eye, and so caused the dislocation upwards. It was curious how exactly symmetrical the two luxations were in Miss McL.'s case.

TRACHELO-RAPHE.

READ BEFORE THE MEDICAL SOCIETY OF
QUEENSLAND.BY WILLIAM S. BYRNE, B.A., M.B., B.CH.,
HON. VES. SURGEON, BRISBANE HOSPITAL.

I AM induced to call your attention this evening to the subject of Emmet's operation for repair of a lacerated cervix uteri from several reasons. It is an operation which has had its ups and downs; it has been praised extravagantly; it has been sneered at with the greatest contempt; it has been said of it that gynecologists were divided into two classes, namely, those who slit up the cervical canal, and those who stitched it together again, an old joke, absurd and ridiculous at the first glance, which has done more injury to this valuable operation than any failures of surgery. Trachelo-Raphe is passing through the stages common to every remedial measure in medicine and surgery; it has been practised extensively and abandoned as useless, and it is now being recommended when everything else has failed. It is at present on its trial, but I firmly believe that though it is by no means a cure-all for uterine troubles, it has a great future before it, and that the real difficulty lies in the selection of cases in which it is likely to prove of the greatest service.

In the three cases which I bring before your notice to-night, the relief of symptoms is complete. In all, the women's lives were burdens to them; they were practically useless as helpmates for their husbands, and were fast entering into the stage of chronic irritable invalids, hysterical and neurotic women, totally unfitted for domestic duties, and in spite of local and general treatment extending over many months, were steadily becoming worse. Now, all three have passed out of my hands; they are vastly improved in their general health, are pursuing the ordinary household duties common to every married woman, and one, after three years of sterility, has become pregnant, in which case it will be interesting to note if the repaired laceration will hold during parturition.

Now a laceration of the cervix may be single, bilateral, or stellate. Theoretically it may be partial, that is, it may be a split in the uterine side of the canal, leaving the vaginal surface intact; but with this latter we are not concerned, as I do not believe it would ever do much injury or require an operation for its relief. The most difficult matter, to my mind, is the selection of cases in which we are to recommend the operation. It may be laid down as a general rule that what a ruptured perineum is to the vaginal walls and uterus, so is a lacerated cervix to the body

of the organ. If there is a slight perineal rupture, it rarely or never interferes with health; so with a slight laceration of the cervix, but if there is a large rupture, involving, perchance, the sphincter ani, we have, as a rule, a host of ills. I say as a rule, for there is a lady at present under my care who sustained a rupture some four years ago, extending into the rectum and destroying the sphincter, an injury from which she suffers nothing, save an occasional diarrhoea, I cannot call it faecal incontinence. But will she always remain so; I fear not; the usual concomitants of perineal obliteration will ensue sooner or later, and there will be prolapse of the vaginal walls and uterus, displacements of that organ, rectocele, and all the complications of such a lesion. So it is with a large laceration of the cervix; sooner or later will come leucorrhoea, granular degeneration of the os, ectropion, subinvolution, ovarian neuralgia, and displacements of the uterus.

We have all seen and felt lacerations of the cervix, some large, some slight, and most of them doing no harm whatever. I do not believe that slight or even moderately large splits cause sterility, unless the condition of the uterus, which arises from their presence, is sufficient to prevent conception. The question thus arises, will a lateral or bilateral tear certainly cause such trouble to arise in the uterus as would justify us in recommending the operation before severe symptoms can arise? I, myself, believe that as in ruptures of the perineal body, a large laceration will almost certainly sooner or later cause symptoms, we should be justified in recommending the operation. If there were a severe rupture of the perineal body, and vague uterine symptoms untraceable to other causes had arisen, I should certainly not hesitate in recommending its repair, and if there were vague symptoms (as distinct from physical signs) of uterine disease co-existing with a laceration of the cervix, I must say I should be very much inclined, as the shortest road to cure, and as a preventative of future ills, to perform Emmet's operation.

Of course, in the cases we see of cervical erosion, ectropion, subinvolution, etc., there is no room for doubt, and surgical interference is an imperative necessity. Small lacerations, as a rule, do no harm, and should, I think, be left alone, unless they are causing symptoms, and that is just our difficulty. It is surprisingly hard to say when you have your patient before you, whether all the symptoms may arise from the slight or moderate laceration, or may the tear be simply a coincidence. Nothing but local treatment and time will clear up this point.

In one of my cases, Mrs. I., the only symptom

was intense pain in the left ovarian region, which had troubled her, off and on, since the birth of her last child, nine years ago; but for the last ten months it has been continuous, and latterly almost unbearable. She had been under my treatment for about eight months, and I exhausted all the drugs and applied every local treatment I knew of during that time without any benefit whatever. There was no displacement of the womb; it was about three inches long, and there was a bilateral laceration, more severe on the left side, accompanied with slight erosion. There was no leucorrhœa, and the menses were scanty. When the torn edges were separated by the finger she always shrunk, and on several occasions she told me that that was the spot to which she referred all her pain. There was also intense pain on pressing over the region of the left ovary. Now was this a case of what is called ovarian neuralgia, or cervical neuralgia, or was the ovarian pain caused by the condition of the cervix?

I may mention in passing that all three cases were affected with the same pain of varying intensity. Mrs. I. always experienced a certain sense of relief from the use of a ring pessary, but after a time the good effects of this also passed away. As time passed on she became quite unable to be up and about for any length of time, and the only relief she had latterly was in perfect rest in bed. She was losing flesh, looking pinched and worn, and she had several hysterical attacks, there was little or no appetite, and sleeplessness still increased her nervous symptoms. Six months ago I operated, in thirty days removed the stitches, replaced the ring pessary for two months, and she has not had a pain since. She has grown fat and healthy-looking; all her hysteria has disappeared. She is again enjoying her life, and in her husband's words the other night, "it is a pleasure to live with her now."

Let me read to you a short history of case No. 2. Mrs. W., aged 22 years, three children, ever since birth of last child two years ago has been ill. Suffers from vomiting every morning, continuous pain in left ovarian region, cannot walk or stand for any time, is unable to lift any weight whatever, and suffers from profuse leucorrhœa. She has been treated as an out-patient at hospital, locally and generally, for months without relief, and now consents to become an in-patient, willing to submit to any operation likely to do good. On examination there is a large bilateral laceration, ectropion, granular degeneration, and hypertrophy of the cervix, with great hardening, suggestive of malignancy, which state necessitated a month's rest in bed, accompanied with local treatment such as hot water douches, application of glycerine plugs,

&c. Four months after the operation she called on me saying she felt ever so much better, there was no leucorrhœa, there is a very slight pain in the side which is wearing away, is able to follow her usual household duties with comfort, can walk a good distance with ease, and is generally in good health.

Case No. 3 is of much the same type. Mrs. D., aged 26; one child, three years old, since whose birth she has never been well, suffers from intense pain in the left ovarian region, bearing down, backache, profuse leucorrhœa, scanty menstruation, is unable to walk any distance, and is quite unfit for any house-work. She was also a hospital patient, and had been locally treated for months without any amelioration of her symptoms. Condition three months after operation.—She never felt better, pain in the side is quite gone, can walk and work with comfort and pleasure. Six months after, she is rather put about at finding she is again pregnant, suffers much from retching, at which time only she is troubled with the old pain in her side. There is no leucorrhœa, and saving the ills of early pregnancy she is quite well.

I think you will agree with me that the relief of symptoms in these three cases is complete. It is no small matter for a working man to have his wife suffering for months and years from uterine disease, unable to attend to her children and her house, and not in any immediate danger of her life, is quite unable to fulfil the duties appertaining to her daily life. When an operation is suggested to a patient, as a rule, she expects immediate relief, but this is not so with Trachelo-Raphe. In some cases months elapse before its full benefit is felt. The interrupted involution of the uterus usually met with in these cases does not occur with the same rapidity as after parturition. As to diagnosis, it would seem most easy, but mistakes are sometimes made unless examined with Sims' speculum, in fact I am now in the habit of using this instrument in all cases of granular degeneration of the cervix, and lacerations and ectropions that would otherwise escape notice are at once brought into view.

Malignancy bears on this subject also. It is still a debatable point whether a lacerated cervix ever produces cancer. Emmet in his principles and practice of gynecology, writes:—"But finally a change of life is completed when epithelioma springs into existence from the seat of the old injury as a product of perverted nutrition." This is a most important statement if it can be established. There is no doubt that the condition induced by a severe laceration, namely, that of chronic endo-metritis with

cervical hypertrophy, erosion and thickening, is very similar in appearances and symptoms to cancer, and possibly in a patient predisposed to malignant disease, it might prove its starting point, but I have not seen or read of such cases.

One word more as to the condition of my three cases after operation. No. 1 never gave me the slightest uneasiness. No. 2 suffered from a smart attack of pelvic peritonitis, and No. 3 had a severe hæmorrhage, lasting two days, which eventuated in plugging of the vagina.

The stitches in each case were left in thirty days, then a thick ring pessary with a narrow hole was adjusted, and the patient allowed to get about. I should, perhaps, have written a description of the various stages of the operation, but they are found in text books, and I have taken up more of your time than I originally intended.

In conclusion, let me ask you what conditions of the uterus you consider suitable for operation, and do you believe that the state of the uterus and cervix caused by severe lacerations is sufficient to induce cancer?

A CASE OF POLYURIA.

READ BEFORE THE SOUTH AUSTRALIAN BRANCH
B.M.A.

BY W. L. CLELAND, M.B., LECTURER ON
MATERIA MEDICA, UNIVERSITY OF ADELAIDE.

X.Y., æt. 45, was admitted to the Parkside Lunatic Asylum, suffering from melancholia, characterised by extreme restlessness and an uncontrollable impulse to be chewing at something. The mind was so far good that the patient's conversation was rational, but he could not be persuaded that he was not ruined, nor a mass of disease. He had indeed sustained heavy losses, but there was still an ample fortune left, as all his business friends assured him. Owing to his propensity for biting, his clothes were speedily riddled with holes, and smaller articles, such as handkerchiefs and towels, were completely destroyed. He was also extremely hypochondriacal as regards his general health, and complained much of dyspepsia. This latter, I think, was more a gastralgia, for he eat quite enough for

his sedentary habits, and evidently digested it, for he gained in weight. After he had been six months in the Asylum, it was noticed that he was passing a considerable amount of urine. A note was made of the fact, and the quantity measured. The daily average proved to be 150 ounces per diem, of a specific gravity of 1007, and contained no albumen nor sugar. At this time he drank largely of water. My attention was also drawn to his inability to keep his drawers from becoming soiled. This was found to arise from the presence of internal hæmorrhoids. Thinking that the polyuria and the hæmorrhoidal condition might be dependent on a certain lax condition of the coats of the abdominal veins and capillaries, it occurred to me that a drug, such as is contained in the plant *hamamelis virginica* or *virginiana*, might prove beneficial. The plant, a native of North America, is also known by the name of the witch-hazel, probably on account of its peculiar method of blooming. Although a deciduous shrub, the flowers in clusters of three or four, surrounded by a showy involucre, appear in the Autumn, and remain on all through the Winter, after the leaves have fallen off, until the following Spring. As a medicinal plant, it has been known and used for the last twenty years, and yet there still seems to be a considerable, and very undesirable difference of opinion as to its therapeutic value, if any. This seems to be owing to no pharmacological investigations having been made as to its active principle, and its physiological action. An example indeed of the old style of studying the materia medica and their actions. All that I can find on the subject is that the bark contains 8 per cent. of tannin, and a bitter principle (Stillé and Maisch). As regards its physiological action, Lauder Brunton regards it as a vascular sedative, meaning by that a substance which, by increasing the contraction of the vessels, lessens the flow of blood through them. This writer also quotes Dujardin-Beaumetz as being of opinion that its action is specially on venous structures. This all coincides fairly well with the clinical results alleged to have resulted from its employment. But, further than this, we appear to know nothing, nor to what particular active principle its efficacy, if any, is to be attributed, nor by what channel effected. Having satisfied myself as to the condition of my patient, when not under the influence of any drug, I proceeded to give him drachm doses thrice daily of the fluid extract of hamamelis. During the following three weeks, the daily average amount of urine passed was 82 ounces, of a specific gravity 1019. The hæmorrhoids, after the first four days, ceased to

trouble him, and he was enabled to keep himself clean. No attempt was made to lessen the amount of water consumed, for it seemed to me irrational to lessen the amount going into the system, when such a large quantity was running out of it. The result justified this opinion, for the thirst disappeared with the lessened amount of watery urine. Unfortunately, and somewhat to my disappointment, the mental symptoms did not to any appreciable extent improve, but, if anything, became worse. I was, therefore, obliged to try something else that might have a more marked sedative action on the brain. For this purpose I selected codeina, on account of its well-known reputation in diabetes mellitus, and for its sedative properties. I commenced with one grain doses, and pushed the drug on to the extent of 5 grain doses thrice daily, until physiological symptoms, such as twitching of the muscles of the leg, caused me to reduce the amount to 5 grains twice daily. The result of this treatment was that the amount of urine rose again to 150 ounces per diem, and the hæmorrhoids were occasionally troublesome. There was marked improvement in the mental symptoms, and the patient felt himself more under self-control. He ceased to be destructive and took more rational views respecting his affairs. The gastralgia also was less annoying. The result was that he left the Asylum improved. This case would seem to confirm the reputation acquired by hamamelis in certain conditions of the blood-vessels, and shows also that codeina exerts but little influence on a pure case of polyuria or diabetes insipidus. The case also shows that the loss of a considerable amount of watery fluid from the system is not necessarily associated with loss of body-weight.

WE have been requested by Baron Sir Ferdinand von Mueller, K.C.M.G., F.R.S., M.D., etc., Government Botanist in Melbourne, to ask our readers, and especially those residing in the interior of Australia, to favour him, by packet post, with small branches of indigenous fruit-bearing or flowering plants, to enable him to enquire into and report upon their medicinal virtues. Baron von Mueller states that most of the discoveries in the vegetable kingdom during the last centuries have been made by members of the profession, and he trusts that medical men in Australia will not be behindhand in assisting him in the investigation of the physiological properties of the Australian Flora. Any significant assistance rendered will be acknowledged by him in any future publication that may be issued on this subject.

PROCEEDINGS OF SOCIETIES.

MEDICAL SOCIETY OF QUEENSLAND.

THE Ordinary Monthly Meeting was held in the School of Arts, Brisbane, on February 14, at 8.30 p.m. Present—Drs. Little, Neil, Hill, Furley, Tiltson, Thomson, Taylor, Hare, Connolly, W. S. Byrne, Clowes, Shout, King, Owen and Love. Drs. Thorpe, of H.M.S. "Palerma," and Dr. Dunlop were present as visitors.

A letter from the Pharmaceutical Society of Queensland, proposing co-operation with the Medical Society was, after discussion, referred to the Council for consideration. A letter was received from Dr. Albert Dunlop, of Ipswich, forwarding the notes of a case of abdominal abscess following typhoid perforation of the bowel, was read. After private business, Dr. GIBSON gave notice that at the next meeting he would bring forward the following notice:—

"Any member who wishes to bring before a General Meeting of the Society the professional merits or demerits of a candidate for membership, shall be at liberty to do so." Seconded by Dr. W. S. BYRNE.

Dr. W. S. BYRNE then read his paper on Trachelography (which will be found elsewhere in our columns.)

Dr. LITTLE wished to know the object of the use of the ring pessary used after operation—Dr. BYRNE explained that it was more like a rubber ring to embrace the cervix and support the stitches than the ordinary ring pessary.

Dr. HILL wished to know if Dr. Byrne considered that sterility was always a result of laceration, as he had two cases, in both of which several miscarriages had taken place, and he considered these due to the laceration.

Dr. NEIL wished to know if Dr. Byrne pared the edges of the tear before stitching. In Germany it was often the practice to divide the cervix completely through to cure sterility. Dr. BYRNE remarked that the wound of a knife would be different from a lacerated birth tear.

Owing to the lateness of the hour, Dr. Dunlop's case was deferred till the next meeting.

NEW SOUTH WALES BRANCH B.M.A.

THE Annual Meeting was held in the Royal Society's Room, on Friday, 2nd March, 1888, at 8.15 p.m. Present—Dr. Knaggs in the chair; Drs. Ellis, Worrall, Crago, Maher, Martin, Megginson, E. F. Ross, Fiaschi, West, Hankins, Clubbe, Brady, Chambers, O'Neill, Marshall and Scot-Skirving.

The minutes of the previous Annual Meeting were read and confirmed.

The Hon. Treasurer (G. T. HANKINS, Esq.) read the Balance Sheet showing a balance in the bank of £143 2s 10d.

The Hon. Secretary (Dr. SCOT-SKIRVING) stated that he had received a letter from the Bank Manager at Camden, calling his attention to the fact that the widow of the late Dr. Leacock had been left in very straightened circumstances and asking that he (Dr. Skirving) would bring the matter before the profession.

Dr. WEST proposed "That the matter of the Leacock Fund be left in the hands of the Hon. Secretary, and

that a circular asking for subscriptions be sent to the members of the profession." Seconded by Dr. MARTIN and carried.

A letter from the Hon. Dr. Creed, stating that he would be unable to be present at the Annual Meeting, on account of ill-health, and asking that the Annual Meeting might be adjourned until the 5th of April so that he might then read his address.

Resolved that Dr. Creed's letter be received.

The following gentlemen were elected Councillors for the ensuing year:—Dr. Creed, Knaggs, Hankins, Chambers, Fiaschi, O'Reilly, Quafe, McCormick, MacLaurin, Scot-Skirving.

The election of office bearers then took place with the following result:—President, Dr. Chambers; Vice-President, Dr. Fiaschi; Hon. Treasurer, G. T. Hankins, M.R.C.S.; Hon. Secretary, Dr. Scot-Skirving; Auditors, Drs. Crago and Ellis.

Dr. Ellis' letter relating to the Medical Defence Association was read and received.

Dr. ELLIS proposed and Dr. Ross seconded—"That a hearty vote of thanks be accorded to the retiring office bearers." Carried.

Dr. ELLIS proposed—"That this meeting do now adjourn until Friday, April 5, in accordance with the request made by the Hon. Dr. Creed."

SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

MONTHLY MEETING held at the Adelaide Hospital, February 23, 1888. Present:—The President (Dr. Davies Thomas), Drs. Lendon, Mitchell, Poulton, Symons, Todd; Messrs. Aitken, A. A. Hamilton, Hayward, and the Hon. Sec. (Mr. Cleland).

The minutes of the meeting held January 26, 1888, were read and confirmed.

BALLOT.—A. E. Wigg, M.D., M.R.C.S., was elected a member of the British Medical Association, and of its South Australian Branch.

Dr. SYMONS read some notes on pterygium, as occurring in South Australia.

Dr. GORGER's paper on Laparotomy, and notes of cases, was taken as read, owing to the writer's unavoidable absence. Any discussion thereon, or of the subject, was postponed until the March meeting.

Mr. CLELAND read a paper on his experience of the action of a preparation of hamamelis virginica on a case of polyuria and the subsequent employment of codeina, in which the latter failed to produce any effect in diminishing the quantity of urine. (This paper will be found on page 148).

Mr. W. SHEPPERSON, of Burroughs, Wellcome and Co., is now in Sydney forwarding the interests of this firm. New specimens of the Kepler Malt Extract Preparations, as also some of the Zymine and Pepsin in Scales, most excellent aids to Digestion, and which are now used in nearly all the Hospitals of Australasia, are being freely distributed to medical men for trial in their practice. The publisher of the *A.M.G.* will be pleased to present these specimen cases on behalf of Messrs. Burroughs, Wellcome and Co., free of charge, to medical men upon application.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, MARCH 15, 1888.

EDITORIALS.

THE UTILIZATION OF DISEASE FOR THE DESTRUCTION OF RABBITS.

A QUESTION of very great interest is now awaiting settlement—and that is the means which shall be adopted for the supervision of the use of disease for the destruction of rabbits in Australia. The Minister for Lands in New South Wales, in whose department the administration of matters relating to rabbits has recently been placed, has communicated with the Governments of the other Colonies, asking whether they will co-operate with the mother colony in the appointment of a commission to advise on the subject. There is some doubt as to the proposed constitution of this body, as at one time reports are circulated that members of the various Boards of Health are to be chosen, at another, that two gentlemen of special attainments are to be appointed by each colony. We think neither proposition likely to properly fulfil the desired object, for it is evident that the enquiry to be thoroughly satisfactory will have to be conducted in the districts where the suggested diseases will have to be used, and to expect that it will be possible for gentlemen who have settled and attained professional eminence (and no others would be fitting) to leave their homes and practices for months, is chimerical. It might be said that the commission would sit in the capitals and make its report on evidence procured by experiments made by subordinates; but the matter is too important to the whole population to be decided on second-hand information. We think that the more practicable and effective body would

be the one recommended over and over again for some years past by the Editor of this journal, viz:—a human pathologist recommended by the Council of the Royal College of Physicians, London, a veterinary surgeon by the governing body of the Royal Veterinary College of London, a pupil of Pasteur, and one educated under Drs. Virchow and Koch. A body such as this would have perfect freedom from professional ties, would be absolutely disinterested, would be thoroughly competent, would have been appointed in a way which would have been free from local influence, and would be able to make its experiments and tests personally in the districts where the diseases, if used at all, will have to be employed.

It must not be overlooked that the enquiry is a perfectly new departure, and that we have no experience to guide us, and that it is the duty of the various Governments to create an experience by experiments which will enable them to decide as to what had best be done in the interests of the colonies which they rule. The subject is no trivial one, and it is one in which thorough inquiry can be shirked no longer. A decision will have to be come to, for disease will be used; in fact, is being used for rabbit destruction, and unless some exact knowledge is created, the people of Australia will have all the risk and but a small proportion of the benefit they would have, were it carried on under supervision, with an accurate record of the result. Stupid people may say that the use of disease is forbidden by law; this, however, we very much doubt, for we must plead ignorance of any law which would deal with it, except that relating to the ke ping or turning out of rabbits. But even were the law ever so strict we do not see how it would be possible to obtain evidence sufficiently conclusive to convict any person, even supposing he were seen in the very act of sprinkling germ infected fluids on vegetation or other food which would be eaten by wild rabbits.

Rabbits are a great fact, and failing their destruction, ruin to Australia is imminent. We may, in proof of this, point out that the agents of some of the large monetary institutions who have been sent to Australia with the command of millions of money for investment here, have received urgent orders to send home to the heads of their corporations reports as to the prudence of continuing to lend money on property in colonies threatened by the rabbit plague, and the withdrawal, as hinted, of such money, would mean disaster to nearly every one in Australia. Articles on rabbits in Australia now frequently appear in British newspapers, and are exciting alarm and astonishment in the breast of the European investor.

LETTERS TO THE EDITOR.

REMUNERATION FOR PROFESSIONAL SERVICES RENDERED ON BOARD SHIP.

(To the Editor of the *A. M. Gazette*.)

SIR,—Last year, the first holiday for five years, I determined to take a trip round New Zealand for the sake of recuperating. I paid, I think, 20 guineas for a berth and in due time sailed. All went well until the south of New Zealand was reached, when a seaman was thrown over a winch, considerably bruised, and his shoulder dislocated. As the Company carry no surgeons, the officers of the ship requested me to attend the man. I did so, reduced the dislocation, and attended him until arrival in Melbourne. (I also attended a woman, prescribing and dispensing for her, but as she was not a saloon passenger I charged nothing.) After my return home I forwarded an account to the aforesaid Company's agent in Newcastle. He declined attending to it. I then wrote to the Sydney offices. They likewise refused my claim. By the advice of friends, I then wrote to the Head Office in New Zealand, claiming £5 5s. for my services, and they politely (?) inform me that *they* consider £2 2s. sufficient, which they enclose, and inform me that *they* consider that any ordinary medical man should do this professional work "*from sympathy*." Now, if such is their opinion, why do they not carry medical men, ill from overwork, in their ships "*from sympathy*"? Surely the case strikes both ways?

Let us glance for a moment at the rights of the case. Had the injured man been a third class passenger, and unable to pay any fee, then I say no medical man would think twice before doing everything in his power to alleviate the man's sufferings "*from sympathy*." But when the case is altogether different, and the servant of a rich company is hurt, and the services of a medical passenger are called for by the superior officers of the ship, I maintain that that Company should pay the surgeon his just fee, not "*from sympathy*," but as a mere matter of business. Do you not agree with me? Suppose the case had been a legal one, and a lawyer (passenger) called in to mend matters, are we to believe that he would have done his best for his client "*for sympathy*," or would he not have at once got his legal fee? But, Sir, few people even dream of looking upon medical services as they do on other services, and whose fault is it—Simply the fault of medical men themselves. They cut each other's throats, as no other class of men do, there is no union amongst them, and the natural consequence is, that if not despised, at least they appear to me to be considered legitimate prey. As the above complaint is of some importance to travelling medical men, may I ask you for your opinion on the matter, in a footnote to this letter, in the next *A.M.G.*

Faithfully yours,

"ETHICS."

February 8, 1888.

[We think the charge of five guineas not only a just but a moderate demand on the part of our correspondent, this fee being the lowest mentioned for the reduction of a dislocation in the list of fees published under the authority of the Medical Society of Victoria, in which colony the voyage terminated. The cool suggestion on the part of the Secretary of the Steam Company that it should have been done without demand for payment, is an impertinence which is but too natural

to men of his kidney. We regret that our correspondent does not give the name (which, however, is pretty evident) of the Steamship Company which wishes to leave the repair of its damaged employes either to chance, or to the charitable feeling of some poor doctor travelling for much needed rest.—*ED. A. M. G.*]

TRACHEOTOMY IN DIPHTHERIA AND CROUP.

(To the Editor of the A. M. Gazette.)

SIR,—This subject having been locally brought before me, and as difference of opinion exists with regard to it, might I ask through your columns "Should not the operation be performed, not for the disease, but for the laryngeal obstruction, and for that only?" Even Trousseau's dictum does not make that clear enough, and teachers often ignore it.

If the glottis do not admit air, the child dies of asphyxia. That is often the sole cause of death, and that is removable by tracheotomy. The presence of membrane in the trachea is surely no contra-indication, and the low operation (if we accept the dividing thyroid isthmus), while disadvantageous from the depth of trachea, greater risk of blood entering trachea, longer time necessary for operation, possible presence of thymus in children, &c., has no advantage to counter-balance these. To get below the membrane there is no need—if membrane form below the tube a gum elastic catheter passed as often as required will prevent obstruction to air supply.

If the patient dies from the disease or complications, that has no connection with the operation, which is only intended to remove one danger incident to the disease, i.e., asphyxia due to mechanical obstruction of the larynx.

Without touching the pathological identity or dissimilarity of croup and diphtheria, would not a number of lives be saved if tracheotomy were performed, and performed early wherever, in any case, death from asphyxia, due to obstruction, threatened?

Yours, etc.,

G. AFFLECK SCOTT.

Maryborough, Victoria, 13th Feb., 1888.

A QUERY.

(To the Editor of the A. M. Gazette.)

DEAR SIR,—I should like to have the opinion of some of your readers on the following case, which I diagnosed enteric fever. W. S., æt. 22, miner, slight figure, about 5 feet 10 inches high, admitted into Maytown Hospital 21st January, 1888, having suffered for about nine days previously from febrile symptoms, and the last few from diarrhoea. On morning of admission, temp., 101, pulse, 98, strong and hard, pupils small, tongue covered with white coat, no eruption, ordered Dover's powder, with carb. bismuth, diet—milk and beef tea; that evening temp. ran up to 105, pulse, 100, pupils small, a good deal of restlessness, three stools passed during day, watery and yellow, slight epistaxis, saliva constantly being ejected, which patient says he cannot stop. January 22.—Temp., 104, pulse 98, seems easier, tongue red at tip, but still greatly coated, perspires freely, has taken his food well; evening temp., 105,

pulse, 130, mind wandering, two yellow watery stools; ordered acid sulph. aromat. and tinct. opium; talks incoherently. 11 p.m.—Patient quite delirious, has tried several times to get out of the ward, once nearly leaped out of window, man obliged to watch him, ordered chloral draught, but could not get it or any other thing taken—patient refuses everything—cold applications to head, body bathed with water. Jan. 23.—Raving all night, temp. 106, pulse 110, profuse perspiration, wardman administered morphia draught early this morning. No effect, no food taken since yesterday, bowels not opened for twelve hours, no urine passed this morning, very delirious, and quite unconscious with prostration; ordered four ounces wine, which was never taken. At 10 a.m., temp. rising; at 11 a.m., temp., 110, pupils greatly dilated, cold extremities: from this the patient gradually sank, and died at 11.50 a.m. No autopsy. Had never complained of any abdominal pain except first day, when he had slight cramps for a short time.

Faithfully yours,

E. ST. GEORGE QUEELY,

Medical Officer, Palmer District Hospital.

Maytown, Northern Queensland.

DONDERS' MEMORIAL FUND.

(To the Editor of the A. M. Gazette.)

SIR,—As it is impossible to communicate directly with every registered medical practitioner in these colonies, may I ask you to publish in your forthcoming issue the accompanying letter, sent in consequence of my having received from the Netherlands a subscription list set on foot by the Committee of the *Donders' Memorial Fund*. I will at the same time ask you also, kindly to allow acknowledgment in your pages of subscriptions which may be forwarded.

I am, &c.,

JAMES T. RUDALL, F.R.C.S.

[CIRCULAR LETTER.]

DEAR SIR,—Steps are being taken to celebrate the seventieth birthday of an eminent man of science, well known to all of us, by repute at least, both in the field of biology and ophthalmology—Professor F. C. Donders, of Utrecht. It is contemplated to connect his name in a permanent way with the spot where he has lived and worked for more than forty years, by the creation of a fund, devoted to a scientific purpose, and which shall be known as the "*Donders' Memorial Fund*." Should you desire, as I trust you will, to place your name on the subscription list, which has been sent here from the Netherlands, and must be speedily returned, may I ask that you will at once transmit to me the amount you intend to subscribe, as there is but little time to conclude the matter, as far as concerns the medical profession in Australia.

I am, &c.,

JAMES T. RUDALL, F.R.C.S.

Collins Street East, Treasury Gardens,

Melbourne, February 25, 1888.

MY EXPERIENCE WITH SOME OF BURROUGHS' NEW PHARMACEUTICAL PREPARATIONS.

(To the Editor of the A. M. Gazette.)

Mrs. T.—age, 42, of gouty parents, who has suffered from Bright's disease for ten years to my knowledge, and latterly from extreme debility. Sent for me a few weeks ago to attend her during an attack of acute diffused eczema. I placed her under treatment, but after the subsidence of the acute symptoms, and desquamation was taking place, she developed symptoms of hæmorrhagic purpura, which produced intense debility, and necessitating the use of stimulants. Champagne and ordinary wines could not be tolerated, as they produced head symptoms of such grave character that they had to be discontinued entirely. At this stage, Burroughs' beef and iron wine was brought to my notice, so I decided to give it a trial. This agreed with the patient admirably, and answered the purpose thoroughly. From this period her improvement has been most marked and progressive. She has continued to take small doses of the wine from day to day, which apparently has no ill effect on her head whatever. I consider this form of administering iron in combination with a food and stimulant, most suitable for such cases as the one enumerated.

During the desquamatal stage, the irritation was so great as to debar the patient from sleep, and in this condition, after numerous other remedies failed, I found the inunction of lanoline not only to soothe the irritation completely, but to keep the hitherto dry, harsh surface moist and supple, to the intense relief of the patient.

My object in publishing the action of the wine and lanoline in this case, is purely to draw the attention of the profession to the intense relief afforded, and that others may be benefited suffering similarly.

STROPHANTHUS IN CARDIAC DROPSY.

A PATIENT of mine, an old lady, suffering from valvular disease and fatty degeneration of the heart, complicated with diffused dropsy of the lower extremities, had been under the "digitalis and convallaria" treatment for a considerable period, without apparently reaping any benefit whatever. I decided to give strophanthus a trial, and ordered five of the tabloids, to be taken three times a day, which is equivalent to thirty drops during the twenty-four hours. The result was very satisfactory, the patient was most markedly relieved in a very short period, and although it is some time now since I treated this case, no return of the symptoms have been manifested.

I have since tried Burroughs' tincture of strophanthus in a case of valvular disease, combined with hepatic enlargement, with the following result:—Dropsy of the legs, with some amount of ascites, completely disappeared within fourteen days. On this occasion I gave sulphate of magnesia and nitro-muriatic acid in combination with the strophanthus. Digitalis and convallaria had been used for some considerable time, but had signally failed.

I am, yours &c.,
R. W. MURPHY.

Launceston, Tasmania, Feb. 1.

REVIEW.

BRUCK'S GUIDE TO THE HEALTH RESORTS IN AUSTRALIA, TASMANIA, AND NEW ZEALAND.—SYDNEY: L. BRUCK, 1888.

THIS useful and valuable contribution to Australian literature will, we are sure, be heartily welcomed by a large section of the profession, not only throughout the colonies, but also in Europe and America, as the subject, though greatly neglected, is, nevertheless, one of much importance. The work referred to is an exhaustive compilation, and, it seems to us, supplies a manifest want. The first part gives an account of the climates of the different colonies, compiled from official documents. Then follows an alphabetical list of about 200 health resorts in Australia, Tasmania, and New Zealand, giving a concise sketch of each place, with an indication of the climate, and range of temperature, altitude, distance from the coast, objects of interest, particulars of excursions, names of resident medical men, hotels and boarding-houses, the quickest and cheapest routes, and other useful information. If the place be the site of a mineral spring or springs, analyses of the waters are supplied, with their temperature, and the names of the diseases which are benefited by them. In another division the health resorts named have been arranged according to their respective colonies, giving also particulars of the mountains, rivers, lakes, plains, and valleys in each colony. The classification of the health resorts according to their therapeutic indications is unique, and minutely carried out, as will be seen from the following list:—1, acidic waters; 2, muriated alkaline waters; 3, alkaline siliceous waters; 4, aluminous waters; 5, bitter waters; 6, brines; 7, earthy or calcareous waters; 8, ferruginous or chalybeate waters—(a) acidulous chalybeates, (b) saline acidulous chalybeates, (c) sulphate chalybeates, (d) undetermined chalybeates; 9, iodo-bromated muriated waters; 10, mercurial waters; 11, muriated lithia waters; 12, saline waters; 13, sulphurous or hepatic waters; 14, thermal mud baths; 15, indifferent thermal springs; 16, undetermined waters; 17, sea-side health resorts; 18, climatic health resorts—(a) under 1,000 feet above sea-level, (b) from 1,000 to 1,500 feet above sea-level, (c) from 1,500 to 2,000 feet above sea-level, (d) from 2,000 to 2,500 feet above sea-level; 19, health resorts at a high altitude; 20, winter stations; 21, grape cure; 22, whey cure.

The characteristic features of each class are mentioned, as also the diseases, for the alleviation

of which they can be recommended, together with a list of places where the respective spas, sea-bathing, and climatic health resorts are to be found. There is also given a very interesting account of the New Zealand thermal springs districts, by the Hon. Sir W. Fox, K.C.M.G.; a table of definitions of the technical terms used in the book; the different thermometric scales, and how to convert them, the temperature of baths, and a ready way to reduce the weights and measures of the B.P. to those of the metric system, and *vice versa*. Altogether the book is well put together, neatly printed and bound, and leaves little to be desired.

THE CENTRAL BOARD OF HEALTH OF VICTORIA ON LEPROSY IN THAT COLONY.

LEPROSY is a most loathsome distemper, whose course is to be measured by years rather than weeks or months, and happily it does not appear to be spreading in Victoria, as the number of lepers has by death dwindled down from 17 or 18 to 4, and one of the latter is in the last stage of his sufferings. One of the lepers who was placed at the Portsea sanatorium was a Chinese carpenter, who used to go much among the community, and who, being able to speak English, had a fondness for attending public meetings. After some trouble he was induced to consent to be taken to the sanatorium, where he subsequently died. Leprosy is a disease whose origin is somewhat obscure, but it is now most frequent amongst people who live on the sea coast, and who eat unwholesome fish. The disease gradually eats away the parts affected, although during the slow progress of its earlier stages the patient enjoys fairly good health. The Premier, Mr. Gillies, has just received advices from the Royal College of Physicians expressing the opinion that leprosy is not contagious, except in a very low degree, and under very exceptional circumstances, which might be met by providing homes for lepers apart from the community. In *Oceana*, Mr. J. A. Froude, writing of the Sandwich Islands, says:—"There was a separate island, Molokai, given up to lepers, which, if not pleasant, might be tragical. Leprosy is fatally frequent in the Sandwich Archipelago. They try to stamp it out by separating the infected from the healthy, and everyone, high or low, who is seized by the disorder, is removed thither to remain till he dies. This, too, I thought I could be content to read about, but a young Catholic priest was said to be there (let his name be had in honor), who had spontaneously devoted his life to comforting and helping these poor creatures in their horrid exile. Such a man as that might be worth an effort to see."

The leper at Sandhurst is a Chinaman named Ah Lin, about 40 years of age, and who has been afflicted with the disease for about six years. The disease is not spreading, and the other Chinamen take good care that Ah Lin shall not come near them. He is kept in a hut in an isolated locality, and is frequently visited by Sergeant Fahey, who also pays a man to provide the leper with food, and attend to his other wants. This attendant lives in

a hut 100 yards removed from the sick man's. Sergeant Fahey visits the leper almost weekly, and furnishes monthly and quarterly reports regarding his condition. Ah Lin is suffering from what the sergeant describes as "dry" leprosy, which has affected his feet chiefly. The sergeant says that this disease does not spread like "wet" leprosy, and that in China people suffering from the "wet" disease are put to death as incurables, and a source of danger to the community. Except for the condition of Ah Lin's feet he is described by the sergeant as being "a healthy-looking man, well fed, and perfectly contented. He expresses a strong aversion to being removed to the sanatorium." At one time there were two lepers at Sandhurst, but the other man died five years ago. The fact that the present patient has been ill for six years, and that no one else is affected, is held to be strong proof that there is little fear of the disease spreading.

The leprosy enclosure at Ballarat is situate in the ranges, about two miles from Ballarat East Post office, and distant a quarter of a mile from any other habitation. A 7ft. high close fence encloses about one-third of an acre of ground, on which stand two huts, having a single room each, fireplace, and window. These huts are occupied respectively by two lepers—Sam Mack, aged 50 years, who has been there 10 or 12 years, and Ah Yot, 50 years, who has been there about the same time. The huts are kept very clean, making a great contrast to the Chinese houses in the town. The two lepers are attended by a fellow countryman, who, for 7s 6d a week, cooks their food for them, and performs what offices they cannot do for themselves. Sam Mack is in the last stages of the disease; both eyes, the bone of his nose, his teeth and gums, and his ears are gone, and a horrible hole in the front of his head represents his mouth. All his fingers and toes are gone, and he is daily sloughing away. It was proposed to remove these men to Point Nepean, but it was considered that this one could not be moved. He can do nothing for himself, but manages to get about a little on the stumps of his feet. Ah Yot has lost his fingers and toes, and his nose is beginning to subside. He is a very lively invalid, and hobbles about in a cheery way on the remnants of his feet. He keeps his own hut very clean, and, like the other, is so contented that he objects to going to Nepean. They appear to suffer no pain, are personally cleanly in their habits, use plenty of water, and take physic prescribed by their own doctors. They are rationed by the Government, the food being supplied through the police authorities. No animals, except Ah Yot's cat, are kept in the enclosure. Altogether during the last 25 years 19 cases of leprosy, all among Chinese, have been treated here. From 1861 to 1865 the lepers were kept in a house within the Ballarat Hospital grounds, and were in the list of patients there. From the annual lists of patients it appears that there were three there in 1861, one of whom died. In 1862 two more were admitted; of the four two were discharged in the same year "cured or relieved." In 1863 three more appeared, two being discharged "cured or relieved," and the remaining three were sent away in 1865 "cured or relieved." From that time the lepers' camp at Ballarat East has been in existence, and early in the 70's there were three lepers there. Lepers were sent to Ballarat from all parts of the colony, until in 1878 there were nine in the lazarette. From that date they have died, one by one, and the residents, protesting against the place being made a receiving-house for all the lepers of the colony, no more have of late years been sent there, and now there are only the two. Five huts were standing in the enclosure about four years ago, until on its becoming known that a fresh tenant

was ready for one of the empty ones, the municipal authorities had the three unoccupied ones pulled down and burned. This procedure was effected, and no fresh cases have been sent to the Ballarat lazarette since the Government established one at Point Nepean. One case of leprosy occurred here in 1886, and the man was promptly forwarded to Nepean. Some of the lepers here lingered for nine or ten years, apparently in no pain, until they fairly fell to pieces. Some died at about 25 years of age, and others at 60. Some of the Chinese are dreadfully afraid of the disease, and two lepers were found by the police in the Chinese quarter, Ballarat East, in the first stages of the disease, their countrymen raising a noise about them being in the camp. It is authentically stated that, in the case of one leper here, he was carefully tended by his brother, who washed him, fed him, and slept with him for four years. The leper died after some years' suffering, and the brother, as far as is known, never contracted the disease. In 1885 the Chinese at Ballarat East and Haddon informed the police that a Chinaman named Ah Fang had leprosy. He was examined by doctors, who said he had the disease. He had lost the top joints of two fingers, and was said to have the characteristic scales of the disease on the soles of his feet. He persisted, however, that he had not leprosy, said he had had the joints burnt off when cooking on a run, and declined to go to the enclosure. One night he cleared out from there, and is now wandering over the colony—perhaps cooking again. It would appear that under the present state of the law the police had no power to compel him to go into the leper camp. Whether the disease is decreasing in the colony or not is not certainly known, but there are fewer cases now than ever there were since 1861, and last year no fresh case was reported. About 10 years ago a man named Hollis used to treat the lepers with some medicament he had compounded, and there was a temporary improvement in their appearance, but the insidious disease soon resumed its ravages.

A COPY of the correspondence which has passed between the Royal College of Physicians, England, and the Colonial Office, on the subject of the contagious or non-contagious nature of leprosy, has been forwarded to the Governments of the various colonies. Sir Henry Holland, Secretary of State for the Colonies, wrote to the college pointing out that in 1867 they had expressed the opinion that leprosy was not contagious, which was contrary to the belief of many medical men in the colonies, where leprosy was known to exist, and where segregation was recommended. The reply of the Royal College of Physicians was to the effect that they were quite aware of the great difference of opinion as to whether leprosy was contagious, but the limit of contagion, if any, must be very low. Compulsory segregation of lepers was not justifiable, but the sufferers might be dealt with in hospitals more of the nature of homes than of prisons. In conclusion, it was suggested that the Imperial Government should appoint the members of the Royal College a commission to inquire into and report upon the disease of leprosy.

THE MONTH.

NEW SOUTH WALES.

In the Legislative Council, on February 16, the report of the Select Committee appointed to inquire into the state and operation of the laws now existing for the regulation of the practice of medicine and surgery in New South Wales, was unanimously adopted on the motion of the Honorable J. M. Creed, M.L.C. The representative of the Government in the Legislative Council, the Honorable Mr. Simpson, promised that the report would be considered by the Government, and that the introduction of the requisite bill ought to follow as a matter of course.

In the Legislative Council, on February 16, the Hon. J. M. Creed, having obtained leave, brought in a bill "To amend the law relating to the registration of births, marriages and deaths," and the bill was read a first time.

In accordance with requirements of the 15th section of the "Anatomy Act of 1881," the Governor, with the advice of the Executive Council, has approved of a further extension of time within which a certificate of the interment of a body shall be transmitted by the authorities of the School of Anatomy to the Inspector of a District, from ten weeks to six months.

At a meeting of the Senate of the Sydney University, held on February 6, an application was received from the medical students who had passed their final examinations, for immediate admission to the degree of M.B. and M.Ch., in order that they might commence medical practice without any delay. It was resolved that the application be acceded to and that the degree of M.Ch. be granted at the commemoration on April 14. The degree of M.B. was then conferred upon Messrs. W. G. Armstrong and L. G. Davidson, and authority was given to the Chancellor, or, in his absence, the Vice-chancellor, to confer the degree of M.B. upon other students in a similar position.

THE Council of the University of Sydney, in response to the invitation of the University of Bologna, has resolved that the Hon. Mr. Faucett be requested to act as a delegate to that University, to attend the proposed celebration in the month of June.

At the beginning of the year there were 60 students attending the practice of the Prince Alfred Hospital, Sydney.

In the Legislative Assembly, on March 6, Dr. Cortis asked for leave to introduce a bill to provide for the registration of legally qualified medical practitioners. Mr. Melville opposed the proposal and the House was counted out.

At a meeting of the Board of Directors of the Sydney Hospital, on March 6, Dr. W. Munro was elected Hon. Physician to the institution, in the room of Dr. Clark, resigned, and Dr. Craig Dixon Hon. Surgeon, in the room of Dr. Muskett. Dr. Evans was re-elected Ophthalmic Surgeon. Dr. Henry was elected Resident Medical Officer in the room of Dr. Clay, who was appointed to the position of District Surgeon in the room of Dr. W. Munro.

A FEMALE patient aged 49, died at the Alfred Hospital, Sydney, on February 24, whilst under the influence of chloroform, prior to an operation for the removal of the breast for cancer.

IN the Supreme Court, Sydney, on March 1, Dr. E. L. Piercy, of Wagga, brought an action against Mr. G. T. Baker, manager of the Union Bank, at Wagga, and a member of the committee of the local hospital, for £3,000 damages for slander. The jury, without leaving the box, believing that the alleged slanderous words were not used, found for the defendant.

MR. W. H. PALING, of George-street, Sydney, has offered his estate at Camden, consisting of 450 acres, with the entire plant and stock, together with the sum of £10,000, for the purpose of establishing and endowing a hospital for convalescents.

DR. W. G. ARMSTRONG, who lately passed his final examination at the Sydney University, has commenced practice at 12 Regent Street, Redfern (Sydney).

DR. W. R. CLAY, who for the past 18 months has been Resident Medical Officer at the Sydney Hospital, and who has now resigned to enter on private practice at Rockdale, was on the evening of February 29, entertained at a farewell dinner by his friends at the hospital.

DR. THOMAS DIXON, Lecturer on Materia Medica, at the Sydney University, has returned from his trip to Scotland, and resumed practice at 263 Elizabeth Street, Sydney.

DR. B. SCHWARZBACH, Specialist for diseases of the eye, will leave Sydney this month by the s.s. "Zealandia," for a twelve months' trip through America and Europe.

DR. J. SPARK, a new arrival, has commenced practice at Katoomba, on the Blue Mountains, 65 miles W. of Sydney.

DR. H. W. SWAYNE, late of Ballina, and formerly of Penrith, has removed to Tenterfield.

NEW ZEALAND.

DR. H. B. LEATHAM, of New Plymouth, has been appointed a Certifying Officer under section 139 of "The Public Health Act, 1876," for the Districts of Hawera, Inglewood, New Plymouth, Opunake, Patea, Stratford, Waimate Plains, and Waitara.

DR. T. L. BANCROFT has resigned his position of House Surgeon at the Christchurch Hospital; Dr. Bancroft intends to settle in Tasmania.

DR. J. E. RIDDELL, a new arrival, has commenced practice at Herbertville, 89 miles from Napier.

DR. R. H. TODD, formerly of Waverley, near Sydney has commenced practice at Hororata, 43 miles from Christchurch.

QUEENSLAND.

THE Queensland Medical Board have caused the following notice to be inserted into the *Government Gazette*:—"It having been ascertained that one Sidney Edwin Herbert, of Muttaborra, has obtained his registration from the board by fraudulent means, the said registration is hereby cancelled, and his name erased from the medical list of duly qualified medical practitioners of this colony."

DR. JOS. BANCROFT, of Brisbane, has been appointed by the Government to represent Queensland at the proposed intercolonial rabbit conference in Sydney.

DR. H. C. PURCELL, of Brisbane, has decided to offer himself at the general election as a candidate to represent the electorate of Nundah in the Legislative Assembly.

DR. W. F. THURSTON, of Rockhampton, has returned from his trip to America and Europe, after an absence of eight months.

DR. J. T. WILLIAMS, a new arrival, has settled at Townsville.

J. C. LUBIENSKI, (*alias* "Dr. Caesar,") who on January 31 was fined £20 at the Croydon Police Court for practising as a doctor without being duly qualified, was, on February 7, fined £10, or six months' imprisonment in Townsville Gaol, for having the sign "Chemist and Druggist" over his shop, he not being registered under the Pharmacy Act.

SOUTH AUSTRALIA.

AT a meeting of the S. A. Central Board of Health, on February 14, a letter was received from the Secretary of the Victorian Central Board of Health, requesting that on the departure of mail steamships for Melbourne a telegram be sent to the Health Officer at the Quarantine Station, Point Nepean, notifying whether the vessel has been cleared by Dr. Toll or his medical assistant, or otherwise by a non-medical officer. Such information would be highly convenient to the steamships, as well as to the Health Officer, as, in the event of having to inspect, he would be in readiness in the launch and not keep the vessel waiting. The S. A. Board, however, considered that in the interest of public health a satisfactory inspection should be made at all ports of arrival, and that any arrangement calculated to prevent such inspection would be undesirable.

AT a recent meeting of the Council of the University of Adelaide the report of the Faculty of Medicine, asking the opinion of the Council whether they will be prepared to consider any scheme whereby legally qualified medical practitioners of a certain standing may obtain the M.B. degree of this University after examination, without being compelled to attend lectures, in some such manner as a medical degree can now be obtained at the University of Durham, was read. It was resolved that the Faculty of Medicine be informed that the Council will be prepared to consider any such scheme, without, however, committing themselves to the principle involved.

THE Bishop of Adelaide and Professor Lamb have been appointed delegates to represent the University of Adelaide at the eighth centenary of the University of Bologna.

DR. J. P. BAKER, late of Strangways, has removed to Balaklava, 67 miles N. of Adelaide.

DR. A. W. HILL, of North Adelaide, has removed to Terowie, 140 miles N. of Adelaide.

DR. F. W. MONSELL, a new arrival, has commenced practice at Kapunda.

VICTORIA.

THE following practitioners have been appointed Justices of the Peace, viz.: Drs. G. Le Fevre, M.L.C., Melbourne; W. J. Bird, Boort; W. Gregory, Kerang; O. Penfold, Sandhurst; H. W. B. Gamble, Walthalla; G. A. Branson, Tungamah; and J. W. Harbison, Numurkah.

THE following gentlemen have applied for the positions of four additional Honorary Medical Officers to the Melbourne Women's Hospital, viz.: Drs. Rothwell, Adam, Astles, Doyle, Elsner, Hooper, Joyce Meyer, O'Sullivan, Peacock, and Power. The election is to take place on March 27.

DURING the week ending February 18, 109 cases of typhoid fever were reported to the Central Board of Health, 12 of which were fatal.

TYPHOID fever continues to be very prevalent at Sandhurst.

OPHTHALMIA is very prevalent in the district of Kaniva.

DR. JAMES ROBERTSON and Dr. J. Fulton, who for more than twelve years were Honorary Medical Officers of the Melbourne Hospital, have been elected Consulting Surgeons to the institution.

DR. R. H. DUNN, Resident Surgeon at the Maryborough Hospital, while returning from Timor in a buggy on February 19, was thrown out, owing to the horse shying, and sustained severe bruises about the head and body.

DR. J. W. Y. FISHBOURNE, of Moonee Ponds, has been appointed an Official Visitor to the Hospitals for the Insane, Melbourne district.

MR. ERNEST JOSKE, LL.B., has been appointed to the position of Registrar to the Dental Board of Victoria.

DR. W. MOORE has resigned his position of Demonstrator of Anatomy at the Melbourne Medical School.

DR. W. J. CARROLL, late of Werracknabeal, has removed to Wangaratta.

MEDICAL APPOINTMENTS.

Allan, Robert John, L.R.C.P. Edin., M.R.C.S.E., to be Government Medical Officer and Vaccinator for the district of Raymond Terrace, N.S.W.

Anderson, Alfred Victor Millard, M.B. et Ch. B. Melb., appointed Resident Surgeon at the Alfred Hospital, Melbourne.

Carroll, William Joseph, L.R.C.S. Irel., to be Public Vaccinator at Wangaratta, Vic.

Dunlop, James Dunlop, M.B. et Ch. M. Edin.; L.R.C.P. et R.C.S. Edin., to act as Medical Officer to attend to the Destitute Poor and Aborigines, within the district of Glenelg, S.A.

Goode, George, M.D. et Ch. M. Dub., to be Government Medical Officer and Vaccinator for the district of Orange, N.S.W.

Harkness, Edward, L.R.C.P. et R.C.S. Ed., L.F.P.S. Glas., to be Public Vaccinator at Doncaster, Vic.

Harris, John, M.D. et Ch. M. Aberd., L.R.C.P. et R.C.S. Ed., to be Honorary Surgeon of the Hunter River Reserve Corps of Volunteer Light Horse, N.S.W.; also Government Medical Officer for the district of Newcastle, Visiting Medical Officer to the Hospital for the Insane, and Surgeon to the Artillery Force at Newcastle, N.S.W.

Hill, Alfred William, M.R.C.S.E., to act as Medical Officer to attend to the Destitute Poor and Aborigines for the districts of Gumbowie and Terowie, S.A.

Lane, Charles Timon, M.B. et Ch. B. Melb., to be Public Vaccinator for Camberwell, Vic.

Mackenzie, John Hugh, F.R.C.S. Ed., to be Health Officer for shire of Poowong, Vic.

Riddell, James Edward, L.R.C.S. Irel., to be Public Vaccinator for the district of Walnut, N.Z.

Swayne, Herbert Wigan, M.R.C.S. Eng., to be Government Medical Officer and Vaccinator for the district of Tenterfeld, N.S.W., vice Dr. J. M. Warren, resigned.

Vaughan, Alfred Purdue, M.B. et Ch. B. Melb., to be Health Officer for shire of Nunawading, Vic.

HOSPITAL INTELLIGENCE.

THE number of patients under treatment at the Prince Alfred Hospital, Sydney, during the past year, were as follows:—Remaining in hospital on 31st December, 1886, 159; admitted during the year 1887, 2,056; total number under treatment, 2,215; discharged well or convalescent, 1,449; discharged relieved, 202; discharged unrelieved, 180; died, 203; remaining in hospital December 31, 1887, 181; average number resident daily throughout the year, 197; mean residence of each patient in days, 28; rate of mortality over all the cases under treatment, 9.16; number of attendance of out-patients, including casualty cases, 22,770. The number of patients under treatment during the year had again considerably increased as compared with that of the preceding year, whilst the results had been even more satisfactory, the percentage of recoveries having been greater and of deaths less. The death rate, which was 9.97 in 1886, had fallen to 9.10, which number included those admitted in a hopeless or moribund condition, as well as a considerable number in the last stage of phthisis. The department for out-patients showed a much larger number of attendances than during the year 1886, the increase being no less than 2,977. Reckoning the usual average of four attendances for each patient, about 5,700 individuals had received the benefits of this department. Of the 2,056 patients admitted during the year, 1,125 were surgical, and 931 medical cases. The average length of residence of patients generally had been 28.6 days, as against 29.4 last year. The length of residence of patients received under orders from the Government had been 36.4 days, whilst those paying for, or contributing towards, their support, have had an average residence of 26.6 days, and the accidents and other non-paying cases 23 days. The total number of cases of typhoid fever admitted during the year had been 160. This was less by 37 cases than during the previous year. The death rate among typhoid cases had been 18.1 per cent., which was higher than that of last year, but still unusually low.

THE number of patients admitted into the Sydney Hospital from 1st January to 31st December, 1887, has been 2,512. Of these, 1,572 were surgical, and 940 medical cases; 1,750 were males, 940 were females. The largest number of admissions was in the month of October, 249; the smallest in the month of January, 173. The number of accident cases admitted was 906. The number of accidents and urgent cases attended to by the resident medical staff, but not admitted, has been 3,829. The number of patients treated at the out-door ophthalmic department for the year ending 31st December, 1887, has been 426; at the ear, nose, and throat department, 209; at the out-door department for diseases peculiar to women, 221. The number of patients treated at the dental department was 127. The number of deaths during the year has been 252, viz., 193 males, and 59 females. Of these 87 died within 48 hours of admission, and many others were admitted in a hopelessly diseased or maimed condition, for whom all the best efforts of the institution were employed to alleviate their sufferings. The number of cases treated by the district surgeons in connection with the dispensary was 6,917. Of these, 486 were visited at their own homes. The total expenditure for the year had been £16,586 2s 11d., and the receipts from all sources, £16,151 16s 1d.

NINETY-FIVE patients were received into the Tambo (Qu.) Hospital during 1887, and 20 others were afforded out-door relief. Three patients out of the

total were forwarded to Dunwich, 73 discharged cured, and 9 died, leaving 10 in the hospital at the end of the year.

A new hospital has just been opened at Molong (N.S.W.)

It has been decided to erect a new stone hospital at Broken-hill, at a cost of \$5,000.

OBITUARY.

RICHARD HEATH.

RICHARD HEATH, M.R.C.S. Eng., 1850; L.S.A. Lond., 1830, died at Flemington, near Melbourne, on February 9, at the ripe age of 79 years. The deceased gentleman arrived in Victoria in 1858, and took up his residence in Geelong, where he interested himself in local and other affairs. He was returned to Parliament and represented West Geelong in the Legislative Assembly during the M'Culloch and Sladen administrations. He was a justice of the peace, and until lately often sat on the North Melbourne Bench. He was also Resident Medical Officer, for several years, of the Melbourne Benevolent Asylum. Prior to his departure for Australia he held the appointment of Surgeon to the Queen Adelaide Lying-in Hospital in Dublin.

CHARLES DAVIES.

DR. CHARLES DAVIES, J.P., M.D. France, 1838, died at his residence at Beaumont (S.A.), of heart disease, on February 12, aged 74 years. The deceased gentleman was a native of Wales, and was educated in France, where he studied and became an excellent French scholar. He arrived in South Australia about forty years ago, and was elected a member of the Legislative Council in 1857. He took his seat in the first session of the first Parliament of South Australia, serving until 1864. He lived in Kermode-street, North Adelaide, for several years, devoting himself energetically to his profession as a medical man, and acquired a large and lucrative practice. In 1859, and for several successive years, he was appointed one of the Visitors to the Lunatic Asylum, and held other positions of usefulness as a citizen. He took a great deal of interest in the welfare and working of the Adelaide Hospital, and served on the Board for some years. He was also a member of the Board of the Botanic Garden. About twenty-four years ago he relinquished active practice in the medical profession, and embarked in the pursuit of sheep farming.

MR. BRUCK, importer of Surgical Instruments, Sydney, has just received some of Morel's New Apparatus for generating and injecting carbonic acid gas into the rectum for phthisis; also some beautiful models of the larynx.

MR. L. BRUCK, Medical Bookseller, Sydney, desires us to state that he has received a full supply of Cassell's *Year-Book of Treatment* for 1887; Mr. Bruck has also a few copies of the *Lancet* from January 1, 1888 (English date), to spare.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Morton, William John, L.R.C.P. Edin., 1886; L.R.C.S. Edin., 1886.
Kelly, Daniel Luke, L.R.C.S. Irel., 1869; L.R.C.P. Edin., 1871.
Weichman, Henry Palmer, L.S.A. Lond., 1877; M.R.C.S. Eng., 1876.
M'Donagh, Augustus William, L.S.A. Lond., 1875.
Armstrong, William George, M.B. Univ. Sydney, 1888.
Davidson, Leslie Gordon, M.B. Univ. Sydney, 1888.

NEW ZEALAND.

Goodall, William Ainalie, M.D. & M. Ch. Vio. Univ. Toronto, Can., 1886; L.C.P.S. Ont., 1886; L.K.Q.C.P. Irel., 1886.
King, Frederic Truby, B. Sci.; M.B. & Ch. M. Edin.
Riddell, James Edward, L.R.C.S. Irel.; L.A.H. Dubl.
Todd, Robert Henry, M.B., Ch. B. & M.D. Trin. Coll. Dubl., 1886; F.R.C.S. Irel., 1887.

QUEENSLAND.

Williams, John Traherne.

SOUTH AUSTRALIA.

Birchall, Thomas Barrow, M.B. & Ch. M. Glasg., 1879.
Monsell, Frederick William, L.R.C.S. Irel., 1886; L. & L. Mid. K.Q.C.P. Irel., 1887.

TASMANIA.

McDonald, William Roderick, M.D. Edin., 1866; M.R.C.S. Eng. 1866.

VICTORIA.

Longden, Frank Reginald, L. & L. Mid. R.C.P. & R.C.S. Edin., 1886.
Nelly, John Francis, L. & L. Mid., R.C.P. & R.C.S. Edin., 1887; L.F.P.S. Glas., 1887.
McEniry, James Joseph, L. & L. Mid., R.C.P. & R.C.S. Edin., 1887; L.F.P.S. Glas., 1887.
Penny, Henry James, L.R.C.S. Irel., 1876; L. & L. Mid. K.Q.C.P. Irel., 1877.

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AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

ON SOME OF THE USES OF COCAINE IN MINOR SURGERY.

BY THOS. BAIN WHITTON, M.D., Q.U.I., &c.,
SURGEON REEFTON HOSPITAL, NELSON, N.Z.

It is about three years since cocaine was introduced in ophthalmic practice, and had its anæsthetic properties been restricted to that alone, it would have been, indeed, "a footprint on the sands of time." But an increased experience of the properties and value of cocaine, with a corresponding decrease in its price, has opened out a far larger field of usefulness, which is being cultivated more extensively each year.

What can be more worrying, both to the doctor and the patient, than an inflamed eye, in which a piece of steel, quartz, or wood has become imbedded in the cornea? And yet these cases are of everyday occurrence in a mining district. But cocaine is the magic wand by which such foreign bodies can be painlessly removed. The "*Lamellæ Cocainæ*" I have never used: the tabloids (gr. $\frac{1}{8}$) can be used, one placed beneath the eyelid, but they cause severe pain for three or four minutes and such an amount of watering that I have given up using them for this purpose; and, instead, wet the point of a very fine camel's hair pencil, lifting up on it about gr. $\frac{1}{4}$, or less, of the cocaine hydrochlorate, and place it beneath the lids. It is unnecessary to use a retractor: place the patient's head well back, keeping the left hand to separate the lids, and the right for using the spud or needle. Should the corneal epithelium be only abraded, the patient can go about his business after the substance has been removed; but if the layers of the cornea be penetrated, it is as well to keep him in view, directing him to bathe the eye frequently with a lotion of boric acid grs. xx., cocaine grs. iv., aq. ad. \mathfrak{z} ii. Should iritis follow from any cause, such as a blow, cold, &c., cocaine grs. ii., and atropine grs. iv., aq. ad. \mathfrak{z} i., as a lotion, will prove very useful. A few months ago a miner was an inmate of the hospital, suffering from a

small, pointed, and pearly-white abscess situated over the lower half of the cornea, which had been struck by some gravel dirt six weeks previously. Of course, he said that there was nothing in his eye, he only wanted the "scum" removed. Having painted the eyeball with a 10% solution of cocaine, I proceeded to break up the abscess, and found embedded in the cornea three large grains of quartz; the removal of these, and scraping the abscess with a small spoon, set up an attack of keratitis, followed by a small nebula; but, with rest, bandaging, and the instillation of atropine and cocaine, both of these disappeared in a fortnight.

A bushman was struck on the cornea by a chip of wood, there was no wound or abrasion of the surface, but in five days keratitis and an abscess followed from the blow; the abscess formed beneath the cornea, over the inner layer, and was incised on its reaching the surface. As it was over a week in maturing, the pain was subdued by the instillation of cocaine three times daily; a gaping ulcer was the next stage, which required touching with argent. nitrate, fused on a very fine probe, but the application was rendered painless, by previously placing a few crystals of cocaine on the wound. The ulcer healed in a month, but left a small nebula over the centre of the pupil. In applying caustics, fluid or solid, to granular lids, tinea tarsi, &c., a few crystals of the alkaloid, rubbed in with the forefinger, is better than a solution.

I find that we cannot discard the chloroform in children with eye troubles, the cocaine acting with them as with their elders; but no sooner does the doctor attempt to examine a child's eye, than a fierce struggle commences, which is only terminated by giving the refractory little patient a few whiffs of chloroform; then, in case of an ulcer or abscess, the cocaine can be dropped in. During the past year I have been using cocaine as a local anæsthetic in various surgical performances. When the solution is applied to the unbroken skin, excepting the mucous surfaces, the anæsthetic effects are disappointing; I have opened several small abscesses, tumours, &c., on the neck, face, and hands, which had been covered, for eight or ten minutes previously, with absorbent cotton wool soaked in a solution of grs. iv. to the drachm; and, in each case, there was a certain amount of pain experienced during the second or two of drawing the knife up through the skin. A method which has more promise of success is that of rubbing in lanoline, or oleic acid, in combination with the alkaloid, a few minutes prior to the incision. A few days ago I opened a chronic

abscess over a man's neck which had been well rubbed with four grains of cocaine to half a drachm of lanoline; he said that he did not feel the slightest pain from the knife, and he was a person of a nervous temperament.

Though the lanoline may convey a sufficient quantity of the cocaine through the skin to cause painlessness in opening an abscess, I could not depend upon it alone in the removal of a tumour, or the amputation of a finger or toe; recourse must be had, in those cases, to the hypodermic injection of the anæsthetic.

J. H., a strong, healthy man, had an epithelioma removed from the centre of the lower lip, the size of a marble. The growth and the mucous surface of the lip were painted with a 20% solution, and four grains dissolved in a drachm of water were injected in four separate places, on each side of the growth as well as below it, adjacent to the proposed line of incision, and on the inner side of the lip. After waiting five minutes, the usual V incision was made, the bleeding controlled, some more of the solution painted over the cut surfaces, and two hare-lip pins inserted. No pain was felt during the incision; he only complained as the last insertion was made with the pin. The wound was healed in seven days by the first intention.

J. C., a man aged 60, was admitted into Reefton Hospital February 10, suffering from an epithelioma of the lip, which was removed as in the former case; the incision extended to the chin, and included about one half of the lower lip. The injections into the inner surface of the lip, as well as on each side of the growth, were of the same strength as in the previous case. It was impossible to insert the needle into the hardened mass of epithelioma in either of these cases. In addition to the hypodermic injections inserted, the chin and all the surface of the lip was well rubbed over, half an hour before the operation, with grs. v. cocaine, dissolved in mxx. of oleic acid. The patient felt no pain.

C. B., July 28, 1887, a strong, healthy man, received a crush of his little finger, between a wire rope and a pulley, which had to be removed at the second phalangeal joint. The finger was painted two or three times with the 20% solution, and two grains of the salt, injected by three separate needlings over the distal end of the wound. This man held his hand without a tremor during the removal of the joint and the insertion of sutures. The wound was dressed with iodoform and gauze, and healed by granulation in six weeks, leaving a nice stump.

W. C., August 3, 1887, a middle-aged man, was admitted into the hospital with a severe crush of the second phalanx of the middle finger. Cocaine, in gr. i. injections, was used as in the

last-mentioned case, and with the same results, but the solution was not used on the finger, as it was covered with blood.

Cocaine must prove of valuable help during the insertion of sutures; I have now used it many times in wounds of the face, scalp and scrotum, &c.; the patient when told that he will feel no pain keeps quiet, and allows time for the accurate adjusting of the edges of the wound. A youth presented himself with a deep wound across his forehead, caused by the blow of a windlass handle; I washed all the blood away, sponged it with a solution of hydrarg. perch. (1—4000), and, when dry, painted the wound, but especially the under surface of the edges, with the strong solution of cocaine, and then inserted four horse-hair sutures. He felt no pain, and was surprised when told that all the "stitching" was finished.

Another case. After severe sloughing of the scrotum, from extravasation of urine, a large cavity, four by three inches in extent, was the result, and, in order to obtain a satisfactory granulation, the edges of this cavity were joined by seven catgut sutures, having had them well brushed, the under-surfaces as many as four times, with grs. v. to the drachm of the anæsthetic. This patient was greatly interested in the painless operation, which had to be repeated on two more occasions, from the amount of tension; with silk, a failure also; finally, three silver wire sutures, in loops of an inch long, were tried, and with success. Of course, the solution was painted on each time of suturing, and with equally favorable results. This man had not recovered when a boy was admitted suffering from a wound of the scrotum, four inches in length, with a protruding but uninjured testicle, caused by a kick from a horse. The silver wire sutures were employed, having the parts well brushed with a solution of the same strength. The results were as gratifying to patient and surgeon as in the last case.

A few days ago I removed a fibrous tumour, the size of a large walnut, from a young girl's breast, under cocaine: four grains of the salt were rubbed up with half a dram of lanoline, and this was thoroughly rubbed over the site of the tumour ten minutes previous to the operation, as well as the hypodermic injection of half a grain in four separate spots around the tumour; no pain was experienced during the insertions of the needle: the incision and suturing being likewise painless. This is the largest tumour which, as yet, I have removed with cocaine, and I shall in future discard the application of the solution to the unbroken skin and use the lanoline ointment instead, with numerous hypodermic injections, according to the area to be operated on. I have had no fainting, nor has any feeling of weakness been complained

of, but should such at any time occur, recourse would be had to the giving of brandy, to the injection of ether, or to the inhalation of amyl nitrite.

In circumcision ; in excision of the tonsils ; in removal of an eyeball, or of a nasal polypus ; and in evulsion of a toe nail, the use of cocaine will be invaluable ; but I cannot speak from experience, as yet, in any of these operations. I have found, in two cases of slight burns, that lint dipped in the 20 % solution subdued the pain completely for about an hour, when it returned, requiring the renewal of the sedative, but this, at the present price of the drug, was too expensive, compelling me to have recourse to a very cheap and very come-at-able sedative—soda bicarbonate, in a saturated solution. Another question, as important as the price of the article, if not more so : May not the absorption of cocaine in a large quantity and over an extensive area of denuded skin, prove injurious ?

In teeth extraction cocaine has proved disappointing to me. I have held to the gums, by means of the forceps, a few moments before extraction, absorbent cotton wool dipped in the strong solution, but have noticed that it caused little or no anæsthesia ; as for rubbing some on the gums first, then injecting some more by a specially curved needle, and at last extracting the tooth, the whole proceedings can be summed up in the proverb—that the game is not worth the candle. But, in cases of carious teeth the pain can be relieved by inserting into the hollow tooth, on cotton wool, either of these solutions, which I keep in stock for this express purpose. First, one grain of the salt dissolved in one drachm of oil of cloves ; second, hydrate chloral grs. v., camphor grs. v., and cocaine hydrochl. gr. i., dissolved by the aid of heat. In the earache of children, during the suppuration of small abscesses, as well as in that occurring in adults from boils, cold, and some nervous complaints, a few drops of the 10% solution dropped into the ear frequently will give intense relief to that distracting ailment.

As a palliative in cases of cancer of the tongue and of the fauces, I have found the strong solution brushed over the affected parts very soothing. It also gave relief to the dysphagia of acute tonsillitis, but, as in those cases of scalds or burns, the expensiveness of the drug prohibits its extensive use. And finally, during the removal of foreign bodies from the nostrils of children, in the application of caustics and such-like to ulcers, excessive granulations, corns, or warts ; or in removing the itching of pruritus ani, eczema, and herpes I have found that cocaine is verily a great soother of many of those little ills to which our present civilization is heir to.

EMPHYEMA IN INFANT SIX MONTHS OLD—RECOVERY AFTER FREE INCISION, WITH EXCISION OF PORTION OF RIB.

By OTTO WIEN SMITH, M.B., EDIN.

I SAW, for the first time on August 10, 1887, an infant, T. Mc., who had been suddenly taken ill on July 31. On examining the right side of chest, I found bronchial breathing over the lower half, vocal fremitus very much decreased, very little, if any, movement, complete dullness from base to apex, both anteriorly and posteriorly, and slight bulging of intercostal spaces. The left side was quite normal. The respiration was hurried with very slight cough. The apex beat was felt about an inch to outside of left nipple. Temperature 99·8 Fah. Pulse 120. The head was thrown back, and always kept in that position. The child was being brought up on the bottle, and takes nourishment well. The treatment adopted consisted of bandaging the chest with flannel and giving liq. ammon. acetatis internally.

The child kept in much the same condition for the next twelve days, the temperature never rising above 100° Fah. As there was no diminution in the amount of effusion on August 22 (on which day the child was six months old), I aspirated the chest, and found that the contents were purulent. The pus was very thick and curdy, and choked the aspirating needle. I therefore determined to make a free incision.

On August 23, my partner, Dr. Bain, administered chloroform, and I made an incision two inches long through the skin, parallel to course of ribs, and in right axillary line, I then proceeded to excise a portion of the fifth rib, sufficient to admit a metallic tube of a quarter of an inch diameter, and about an inch in length, with a broad flange to prevent the tube slipping into the chest. A very large amount of thick curdy pus was evacuated, and the little patient bore the operation very well. Fine marine tow was applied over orifice of drainage tube, and the chest bandaged with flannel. On the same evening the temperature was 98·8° Fah., the respiration normal, and the percussion note amphoric over the whole of the right side. The tube was removed and cleaned once a day, and I found no difficulty in replacing it, as is so often the case with india-rubber drainage tubes. I did not use any injections in the after treatment, but directed the mother to frequently place the child on its right side, and as there was a free outlet for all dis-

charge the child made an uninterrupted recovery. On September 30, as there was almost no discharge I removed the tube, and on October 2 the child was sent home. On October 16 I again saw the patient, when the wound was quite healed, he had no cough, looked well and strong, and weighed 16lbs. There was no falling in of chest, and respiration could be distinctly heard all over right side. I may mention that the child cut three incisor teeth while under treatment.

Clare, South Australia.

COMBINED SUPRA PUBIC AND LATERAL LITHOTOMY. RECOVERY.

By STEPHEN FLOOD, M.D., F.R.C.S.I., AND
ERNEST SHEAF, M.R.C.P., F.R.C.S., ED.,
MEDICAL OFFICERS, TOOWOOMBA HOSPITAL,
QUEENSLAND.

J. T., AGED 26 years, was admitted into the Toowoomba Hospital (Queensland), on November 27, 1887, suffering from frequent and painful micturition. The urine contained a quantity of pus and mucus. The condition of the patient was fairly good. On December 19 Mr. Sheaf, with the assistance of Drs. Flood and Bellamy, made the left lateral incision, and readily reached the stone. The stone being too large to extract entire, was crushed by a strong lithotrite, introduced through the wound. The bladder being hypertrophied, and now contracted over the large jagged fragments of stone, they were as difficult as ever to extract. The pieces could not be turned over apparently without further wounding the inflamed lining of the bladder.

The supra pubic incision was made with the greatest care, in spite of which the peritoneal cavity (the bladder being now deep in the pelvis) was opened to the extent of half-an-inch, and a small piece of omentum protruded. This was returned, and a catgut stitch repaired the opening. The bladder was sought for further down, and, guided by a staff, introduced *per urethram*, an opening was made into it. Dr. Flood introduced the lithotrite by the perineal wound, and Mr. Sheaf adjusted the fragments for crushing, with his finger through the supra pubic aperture, and then, through the same wound, the larger fragments were, with some coaxing, removed by a pair of dressing forceps.

Next, an attempt was made to wash the re-

maining debris out with warm boric solution, by a tube inserted through the supra pubic opening. Now arrived to the operators the most distressing and perplexing period of the proceeding, for, having two apertures in it, the bladder would not dilate, and the solution ran out at the perineal wound scarcely removing a single fragment. When, however, a strong stream was urged through the perineal opening, some few pieces appeared above the pubis, which were entangled and removed by pieces of sponge. After the most patient endeavours the irrigation was given up, and as many pieces as could be caught by the forceps (or between the index finger of the right hand and a raspatorium) removed, a few small crumbs still remained. The patient had now been a long time on the table and showed symptoms of collapse; he was removed speedily to bed, no stitches being placed in the wounds, and bleeding having stopped.

Within 24 hours he had pain over the lower part of the abdomen, and within 48 hours bad-smelling vomit. The first three days the temperature was not much above normal. By the fourth day it rose to 101.2. From the sixth to the sixteenth day he passed three or four loose stools each day, when the diarrhoea ceased.

On the 11th day the evening temperature was 100°, and from that time gradually declined. His appetite throughout was very good, and on January 28 he was up and dressed, and on the verandah. To-day, February 17, the upper wound is healed, while in the lower wound there remains a minute sinus which is closing.

The fragments of the stone which were collected weighed over two ounces, but much was lost, and a few particles came away from the upper wound as he lay in bed.

While the surgeons connected with this operation do not record it necessarily for imitation, they offer no apology, feeling sure that the report contains many points of interest to the practical surgeon. Maceration of the freshly cut tissues by urine, is one of the greatest drawbacks to the supra pubic operation, causing that "urine fever" so well described by Mr. Reginald Harrison. (Lettsomian Lecture, B.M.J., January 7, 1888.) The free drainage to the bladder by the perineal incision was an undoubted advantage, proved by the low temperature and absence of shivering in this case, in spite of the severe nature of the operation.

The suggestion might be hazarded that, in some cases, supra pubic lithotomy might be improved upon by making a median incision into the membranous portion of the urethra and inserting a drainage tube. The supra pubic incision would heal with greater quickness and certainty.

A CASE OF HYDATID CYSTS.

By P. T. THANE, L.R.C.P. LOND., M.R.C.S. ENG., YASS, N.S.W.

E. J. C. was first seen on August 5, 1887. She was a thin, young-looking girl, aged 17 years, but did not look more than 13. She was complaining of constant vomiting and jaundice. Her family history was good, father and mother both alive and healthy; she had lost one sister from croup at four years of age. She had never been laid up with any serious sickness, but for some long time past she had had attacks of vomiting with occasional headaches. About 6 months ago a swelling in the epigastrium was first noticed. For the past week she has had constant vomiting, keeping nothing whatever on her stomach, and during this time has had gnawing pain in the epigastrium. About four days ago jaundice first appeared.

Present State.—There is decided jaundice, skin and conjunctivæ being deeply stained yellow. There is a large rounded swelling in the epigastrium, continuous with the liver. The veins are not enlarged over it, and the skin covering it is quite natural in appearance. The surface of it is quite smooth and not tender; it feels hard or rather tense as though it were not solid. It reaches to within half-an-inch of the umbilicus. Quite dull on percussion, and this extends from lower end of sternum to within half-inch of umbilicus, and measures $5\frac{1}{2}$ inches. Measurement round the body 2 inches below sternum is 26 inches. In right mammary line dulness measures $4\frac{1}{2}$ inches. There is no splenic dulness. The heart's apex is felt at left nipple in third interspace; sounds normal. Pulmonary sounds and resonance normal. Tongue is moist, with slight yellow fur; bowels regular. Menses have not appeared yet.

She was seen again on August 13, when she was decidedly better; vomiting had stopped and jaundice less marked. The swelling, however, was larger and more tense, there being an increase of $1\frac{1}{2}$ inches in measurement round body.

Was not seen again until September 17, when the note was, "Has been doing well up to two days ago, when vomiting recurred. Measures one inch less round body." On this day she was admitted to hospital. E.T. $101\cdot2^{\circ}$, P. 96. On the 18th T. 99° , P. 90. Has had a restless night, vomited twice and passed one loose motion. A hypodermic needle was inserted two inches above and one inch to the right of umbilicus, but only a few drops of blood were drawn. Given Hst. Pot. Iodid.: gr. iv., t.d.s. E.T. 102° , P. 100. Has vomited three times, and bowels

open twice. Complained of slight pain after tapping for short time. From this time to October 3, there was decided improvement, tongue got clean, appetite increased, patient put on flesh and expressed herself as feeling much stronger. The Hst. Pot. Iod. was increased to gr. xiv., t.d.s., gradually. The swelling appeared to get less marked, although the measurements kept about the same, and was undoubtedly less tense. On two or three days the centre of the swelling gave quite a resonant note on percussion. On October 3 the heart's apex beat was felt one inch below and half-inch within left nipple.

October 4, 10 p.m.—Has just had a severe rigor, with great heat of skin. She complains of severe pain in the belly as though something was pressing heavily on it. Has vomited several times, at first food, then food mixed with blood, and then pure blood; the blood has an extremely offensive smell; in all about $1\frac{1}{2}$ pints of blood. Bowels opened twice about the same time, dark and confined motions, but containing no blood. At 12, midnight, T. $104\cdot2^{\circ}$, P. hardly countable, R. 48. Complains of severe pain in epigastrium, and save that there is considerable tenderness here, the physical signs remain the same. Ergotine and morphia given hypodermically.

5th.—T. $103\cdot4^{\circ}$, P. 126, very small and weak. R. 30. Slept well after injection; there has been no vomiting until 10 a.m. this morning, when she vomited about one pint of watery fluid containing black flakes, evidently altered blood. There is no pain now. Complains of thirst; face flushed; tongue, which had been quite clean, is pale, dirty yellow, fur in centre, and marked by teeth at edges. There is no distension of epigastrium, complete resonance from sternum to pubes; liver outline not to be felt; less tenderness in epigastrium. Bowels open once, quite black. 10.45 a.m.—Has just vomited more than a pint of pure bright blood. Injection of morphia and ergotine repeated. Nutrient enemata of brandy, milk, and strong beef tea to be given every four hours.

3 p.m.—Has vomited quite another $1\frac{1}{2}$ pints of blood, with very bad smell, and containing a curd of milk quite three inches long.

5 p.m.—Suddenly vomited nearly one pint of thin but pure blood, and died.

Post mortem made five hours after death.

Abdomen somewhat distended; on opening it the liver is seen to occupy the greater part of it. It is enormously enlarged; at the left upper, and back part, and hidden by the diaphragm, are two irregular-shaped swellings, projecting from the surface, each the size of tennis-balls, and both hard. On opening one, perfectly clear fluid spurted out, and internally it is lined with the

usual hydatid membrane; no daughter cyst seen in it. The membrane fits the cavity closely, so presumably it is of recent origin. The other swelling is found to be completely crammed with cyst membrane, and evidently is a hydatid cyst that had been very large and had undergone spontaneous cure and contracted. It contained no fluid at all. The liver appears to be flattened out, so that it reaches one inch below the umbilicus, it is very pale and tough. The gall-bladder, which contains some bile, is under the tenth *left* rib, just under the anterior margin of the liver. On the upper surface of the liver, just above and to the right of the umbilicus is a depressed cicatrix, and this is continuous with a whitish mass on its under surface, the size of a small mandarin orange, and on opening it, it is seen to be another cyst, crammed full of membrane, similar to the above-mentioned one, and, like it, it has evidently been a very large cyst that has undergone spontaneous cure.

The *oesophagus* is exactly in the mesial line, and tracing this down one finds that the stomach lies almost completely to the right of the middle line; it is partly overlapped by the liver, so that when distended a considerable part would be behind the liver. It is adherent to the under surface of the liver, and on dissection a cavity the size of a small mandarin orange is found on the under surface of the liver and opening into the stomach. This opening, which opens through the lesser curvature, is quite close to the pylorus, and is the size of a shilling, it has thin brown edges, and is evidently of some age. The cavity has irregular surfaces, and dirty blackish appearance, and is partly filled with soft, black, blood clot, but contains no hydatid membrane. Opening into this, evidently by ulceration, is a large branch of the portal vein, and this opening is partially filled with blood clot. The opening does not include the whole circumference of the vessel; the size of the vessel is that of a lead pencil. The stomach and bowels are full of dark fluid blood. The spleen is hidden under the *right* ribs, exactly the opposite to its usual position; it is lobulated, and there are three small supplementary spleens about the size of walnuts. The *cæcum* occupies the *left* iliac region, and the ascending colon runs directly upwards from this. The heart, lungs, and kidneys appear normal.

Remarks.—This case is of considerable interest, and partly so on account of its unanticipated termination. My diagnosis from the first was hydatid cyst of liver, and I thought that there was a large cyst between sternum and umbilicus, although the dry tapping did not confirm this. For the last week before the hæmatemesis appeared, the resonance here puzzled me, although after death

it was clearly seen to be due to gas in the stomach, which was overlapped by the liver. Then when the hæmatemesis did come on I was still more puzzled to account for it; there was no rush at all of watery fluid with the blood or before it, or any secondary cysts, as though a cyst had just ruptured into the stomach. However, the *post mortem* examination clearly showed the cause of it. I am of opinion that some time previous to my seeing the girl this cavity contained a large hydatid cyst, which broke into the stomach, possibly during one of the attacks of vomiting, which had often occurred before; that the gastric juice passing into this cavity had digested the walls of it until this branch of the portal vein was opened, so causing the fatal result. The position of the abdominal viscera is interesting; the stomach and gall-bladder doubtless have their positions altered by the several cysts pushing them over as they enlarged, or dragging them as they contracted. But one can hardly imagine that the spleen and *cæcum* could have changed sides from such causes, possibly their unusual position was congenital. I regret that I did not take notice of the arrangement of the peritoneum, but as the examination was made very late at night, I was somewhat hurried over it.

HYSTERECTOMY.

READ BEFORE THE S. A. BRANCH, B.M.A.

By OSCAR GÖRGER, M.D., ET CH.M., STAATS EXAM., HONORARY SURGEON, ADELAIDE HOSPITAL.

(Reported by J. McNaughton, M.B., Junior House Surgeon.)

N.G., unmarried, aged 36, postmistress residing near Adelaide, had good health with the exception of several colds, a diphtheritic croup about 8 years ago, and hæmorrhoids about 5 years ago, which were removed by operation. She had no suspicion of her uterus being in any way affected until about 18 months ago, when not feeling strong, and losing more at her monthly periods than formerly, consulted Dr. Görger, who gave her medicine, which seemed to stop the excessive discharge for a time, but soon had no effect. Was then examined under ether, and a tumour of uterus was discovered. A few days after, on September 16, 1886, Dr. Görger, at his private hospital, removed ovaries by median abdominal incision. Patient made a good recovery, was allowed up on the 11th day, going home at end of third week. There was marked benefit to

uterine condition until May, 1887, when metrorrhagia and menorrhagia came on and persisted, so that patient feeling that the tumour was enlarging consented to undergo an operation at Adelaide Hospital for extirpation of the uterus.

Patient was admitted at 4 p.m., October 31, and put at once into the cottage, which is distant 50 yards from main building. The operation was begun at 8.15 a.m., November 1. The room and contents had been carefully prepared by carbolic acid spray, played for many hours.

Operation by Dr. Görger, assisted by Dr. Poulton and House Surgeons, patient anæsthetized with ether (0.750). The abdominal surface carefully cleaned and vagina douched with corrosive sublimate solution, 1—2000. The cicatricial integumentary tissue of former incision was dissected off, and a straight mesial incision made through the linea alba and peritoneum for five inches. The *intestines* were pushed upwards, and four large soft flat sponges put into the abdominal cavity as the myomatous uterus was drawn out through the wound. It formed an irregularly lobulated tumour about the size of a large fist. The most plainly evident blood vessels were seized with Pean's artery forceps, and ligatured before being cut, and the pedicle needle was used to ligature the tissues with silk at close intervals all around the cervix uteri. Elastic tubing was then tightly wound around the cervix close to the ligatures. A circular collar of peritoneum was then reflected from the body to the cervix, and the tumour (formed by the body of uterus and myomata) was amputated close to the elastic tourniquet. The artery forceps were then taken off as ligatures were put on each bleeding point. The cervical stump was then hollowed out in the middle and a continuous suture put in to draw together the outer parts and prevent oozing. The elastic tourniquet was then removed and a few more ligatures were then found necessary to arrest some free oozing of blood. The peritoneal jacket was then trimmed to meet accurately over the cervical stump. A continuous suture of fine silk was used to stitch the peritoneal cover, so that finally there remained a stump about the size of two thumbs with a peritoneal exterior, marked by a linear incision. The stump was then dropped into the abdomen, and the external wound closed with deep silk sutures, as the sponges were withdrawn from abdominal cavity. A few horse-hair sutures were put in between silk sutures, and the operation was done. Patient was not nauseated by the ether until the last of the stitches were being put in, when she had a violent fit of retching for about one minute. The vagina was irrigated and the wound dressed with iodoform and carbolic gauze, with a liberal covering of

salicylic wool, and a broad mackintosh dressing and flannel binder.

10.30 a.m.—Having been put in bed, not yet conscious. The pulse was 96 per minute and fairly good. Vomiting troublesome.

11 a.m.—Having had injection, Morphia Hypodermica = gr. $\frac{1}{4}$, the pulse has become slower, 90 per minute, but is very weak and compressible, patient is now sleeping quietly.

9 p.m.—(The weather hot and dusty, temp. of wind 80° Fahr., sky very cloudy, air oppressive). Has slept several hours during day. Has had several slight fits of vomiting, especially once after sucking a quarter of an orange. Has had only ice in small quantity. Patient is now awake. Has a cheerful expression, says she has a little pain about the wound. Has not yet had urine drawn off. Pulse strong, quick, rate 120, Temp. 100°. Morphia injection = gr. $\frac{1}{4}$. Urine drawn off.

10.30 p.m.—Patient very quiet, sleeping naturally.

Nov. 2.—Morning. (The temperature fell during night, and to-day is a pleasant cool day.) Has slept fairly well through the night. Was a little nauseated and vomited this morning. Patient is cheerful, feels well. Temperature 99°.

8 p.m.—Has had no recurrence of nausea, feels very well. Has taken a little soda-water. Passed urine at 11.0 a.m.

8.30 p.m.—Temperature 100.2°. Pulse strong, full, 105. Patient feels desire for some fluid food. Borborygmi can be heard when at bedside. Has not taken much hot water. Injection of Morphia = gr. $\frac{1}{4}$. Hot water in teaspoonfuls.

Nov. 3. (Day fine, moderately warm.) 11 a.m.—Patient has slept very well. Has felt a little flatulence, but was not made uneasy. Pulse, 88, temp., 98.8° F. A small amount of reddish discharge comes per vaginam. To take small quantity of milk and soda-water. Douche with thymol, 1—1500.

8 p.m.—Pulse 93, no uneasiness.

7.20 p.m.—(Much rain, thunder and lightning.) Temperature 99.4° F. Pulse 88. Has taken milk and soda-water (about $\frac{1}{2}$ pt.) during the day, no nausea. Patient cheerful and looking well.

11 p.m.—Pulse 84, has not slept. Morphia, gr. $\frac{1}{4}$. No pain, but a little restless.

Nov. 4.—(Day very close, severe thunder-storm and rain.) 9 a.m. Patient slept at intervals during night; feels well this morning. Pulse 80, temp. 98.4°. Has some difficulty in getting throat cleared of mucous phlegm.

11 a.m.—Temperature has risen to 99° F. There have been loud thunder-storms which made patient very uneasy.

8 p.m.—Patient feels uneasy, has not slept during day. Temperature 100° F., pulse 92. Morphia injection = gr. $\frac{1}{4}$.

Nov. 5. (Day fine and cool.) 9 a.m. Patient slept well last night, no pain, no uneasiness.

8 p.m.—Patient feels quite well. Pulse 100, temp. 100.2°. Morphia injection = gr. $\frac{1}{4}$.

Nov. 6.—9 a.m. Patient slept well last night. Temperature 99°.

5 p.m.—Has had several short naps. Has no pain nor nausea. Pulse 96, temp. at 3, 99.4° F.

Nov. 7.—Patient has slept very soundly during the night. Pulse at 9 a.m. 96, temp. 99.2° F. Wound has united, except a piece about $\frac{3}{4}$ inch at middle part, which is granulating. No stitches removed (as strapping is unsuitable for the skin.) Dressed with gauze and iodoform. No motion of bowels as yet. Enema to be given to-day. No vaginal discharge.

7.15 p.m.—Patient has not slept to-day. Pulse 105, temperature 100.8° F. No pain complained of, but feels tired.

Nov. 8. Patient has slept well during the night. Feels well, although pulse = 100, temperature 99° F.

8 p.m.—Temperature 99°, pulse 96. Feels quite well.

Nov. 9.—9 a.m. Has slept very soundly all night. Temperature 98.4, pulse 102.

9 p.m.—Has not slept to-day. Has no pain save a little soreness about abdomen. Temperature 100°, pulse 100.

Nov. 10.—11.15 a.m. Patient slept well last night, but temperature at 7 a.m. = 100.4° F., temperature at 11 a.m. 102.2° F., pulse 128. A malar flush on left cheek. R. Pulv. Glycyrr. Co., grs. lx.

1.15 p.m.—The wound is all united, some silk stitches were found causing irritation and removed. Bowels were fully moved at 4 p.m. and again at 6 p.m. Temperature 8.15 = 100.4°, pulse 114.

Nov. 11.—11 a.m. Patient slept well at intervals last night. Feels well and wishes for some solid food. Temperature 99.3°, pulse 110.

10 p.m.—Pulse 103, temperature 100°. (Bowels moved 4 times naturally).

Nov. 12.—Patient slept well last night, temperature this morning 98.2° F.

8 p.m.—Patient has had solid food to-day. Feels well, pulse 100, temperature 99° F.

Nov. 13.—9 a.m. Patient did not sleep much last night (first night that no morphia was injected). Feels well. Pulse 92, temp. 98.4° F.

8 p.m.—Pulse 100, temp. 99.4° F. Feeling tired, has not slept but a few minutes to-day.

Nov. 14.—Has not slept much during the night. Feeling pretty well. Temp. normal.

8 p.m.—Patient has fallen asleep and is sleeping soundly. Temp. 98.8°. Bowels moved twice.

Nov. 15.—9 a.m. Patient has slept very well during night. Feels well. Temp. 98, pulse 100.

8 p.m.—Has been out of bed from 9.30 a.m. to 6 p.m., resting on bed for one hour at midday. Appetite is improving. Temp. 98.8°, pulse 96.

Nov. 16.—Patient has gone to her own home.

Dec. 23.—Discharge coming from vagina. Some silk stitches removed per vagina.

Feb., 1888.—Enjoys excellent health.

SOME REMARKS ON PTERYGIUM.

READ BEFORE THE SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

By M. J. SYMONS, M.D. et Ch. M. ED.,
HON. OPHTHALMIC SURGEON, ADELAIDE HOSPITAL.

RECENTLY I had an opportunity of inspecting the eyes of over 200 natives of South Australia and was struck with the absence of Pterygium in individuals so exposed to the irritation of dust and heat as are the aborigines of this Colony. This led me to examine my note book, to refer to the authorities, and now to lay before you a few observations on this subject. Firstly let me quote some of the authorities who write definitely on this subject.

Pollock on Histology of the eye. Pterygium.
—This excrescence outside the sclerotic and spreading over the cornea is a circumscribed hypertrophy of the sub-epithelial layer of the conjunctiva, with the usual appearances of that tissue. There are bundles of fibres and also blood-vessels which are more numerous towards the surface than in the deeper parts, while areas, with a homogeneous substance, in which lie many cells, occur, more especially about the margins.

Pinguecula.—This small prominence near the margin of the cornea is composed of dense connective tissue, containing few blood-vessels, with remains of others which have been obliterated, and is covered with a thickened layer of epithelium.

AUTHORITIES.

Alt points out that the apex of the pterygium buries itself a little way beneath the superficial layers of the cornea.

Von Arlt.—A partial degeneration of the conjunctiva caused by an inflammation. A probe can be passed under it to some distance.

A rare form of pterygium and one differing somewhat from that usually seen occurs in the course of an acute conjunctival blennorrhœa where a chemosed conjunctiva becomes firmly united during the process of cicatrization, leaving a portion of the conjunctiva triangular in form

and with an inverted border. A probe can be passed under it.

This kind of pterygium may be distinguished as bridge-like in form.

Pterygia of various forms are observed after a partial scalding or cicatrization of the conjunctiva or the cornea, and also after diphtheria.

Beer was led to believe that pterygium owed its origin most frequently to the influence of lime and fine stone dust upon the conjunctiva, by far the greater number of patients being day laborers who are extremely exposed to this cause.

Carter.—Pterygium is a conjunctival growth which consists of hypertrophy of tissue, it is usually the result of long continued inflammation and is scarcely at all amenable to treatment; the hypertrophied material may be removed by excision or ligature, but the same kind of action is often renewed on the cicatrix, and the patient seldom derives material or lasting benefit from any treatment.

Carter and Frost.—Exposure of the eyes to wind and dust and all other conditions which cause hyperæmia of the conjunctiva act as predisposing causes, but an abrasion of the corneal epithelium as from a superficial ulcer is probably necessary.

Recently the view has been advanced that pterygium is due to the presence of micro-organisms, but the evidence on this point is not conclusive.

Dixon.—Pterygium is seldom met with, except in persons who have passed the middle period in life, but I have now and then seen it in younger men, sailors and others who have spent much of their time in tropical climates.

Hasner pointed out that the connection between the conjunctiva and the sub-conjunctival tissue at the limbus conjunctivæ is often relaxed, more especially in aged persons, and that this forms a frequent predisposing cause of pterygium.

Juler.—Pterygium is thought to be caused by persistent exposure of the conjunctiva to irritating substances, and to commence as a small abrasion or ulcer, opposite the sclero-corneal junction. *It is most common in those who have travelled or spent some years in hot dusty countries, and in stone-masons and others who are exposed to irritating substances.*

Laurence.—The formation of pterygium has been referred to inflammation of the conjunctiva, on what grounds I do not know. The diseased change begins and proceeds without the presence of the circumstances generally admitted to constitute proof of inflammation, while the whole course of the affection, and especially its long duration, are totally different from what we see in inflammatory affections. Individuals laboring under pterygium

are not even found to have been previously subject to inflammation of the eyes.

Lawson.—Patients about the middle age are most liable to pterygium and especially those who have served long in tropical climates. It is seldom seen in the young.

Meyer quotes *Arlt* as to the theory of small ulcers forming at the corneal margin and the cicatricial process dragging on the epithelial tissue, and *Horner*, on his idea of the formation of a pinguecula by the irritation of small foreign bodies, and by the hollow formed between the pinguecula and the corneal margin allowing of the further collection of small particles which cause friction and are liable to cause ulceration of the corneal margin. "The consequent cicatrization draws the conjunctiva on to the cornea."

Morgan says pterygium may occur at any age, they are most common in the middle or later periods of life. Residents in warm climates are said to be particularly subject to this complaint.

McKenzie says, many writers have considered pterygium as a consequence of ophthalmia, but this opinion appears to be incorrect. It is true, indeed, that tedious or neglected, or ophthalmia treated with many relaxing external applications, is apt to leave the conjunctiva of the eyeball so loose that at every motion of the eyeball it falls into a number of folds, but such cases however, never appear to terminate in pterygium.

Nettleship.—It is rarely seen except in those who have spent some years in hot countries

Noyes says it occurs in adults, especially of the middle life, and more amongst those who are habitually exposed to the weather or to an irritating atmosphere, such as sailors, farmers, &c. Among such persons chronic conjunctiva is common, and if an ulceration occur at the border of the cornea, and extend to the adjacent conjunctiva, the ulcer in healing will drag over a little of the relaxed mucous membrane to the cornea, with renewed attacks of inflammation; this process advances and the apex of the pterygium is preceded by a slight ulceration. The special looseness of the conjunctiva at the inner side of the globe, where we have the plica semilunaris, and the predominance of the act of convergence above other movements of the eye, accounts for the prevalence of pterygium in this region. In many cases there is no evidence of an ulceration in the cornea. On the contrary, microscopic examination shows that the corneal part of the growth has epithelium, not only on its anterior surface, but also on its posterior or applied surface. (*Schweigger*.) Also on the sides of its pointed part there is an unfolding of the tissue under which a fine probe can be thrust a little way.

Power says this is an affection of a very

curious and anomalous nature, the *ætiology* and pathology of which have not as yet received a very satisfactory explanation. *The disease appears to be most frequent in those who have resided in warm climates.*

Soelberg Wells.—The causes of pterygium are often somewhat obscure and uncertain, as its formation is generally very slow and gradual. *There can be no doubt that long and constant exposure to heat, glare, wind, dust, and chemical irritants may produce it, by setting up a state of chronic irritation of the conjunctiva, which gradually leads to a thickening and hypertrophy of this membrane. This occurs particularly in situations which are specially exposed to these influences, viz., at the inner and outer angles of the cornea, which lie in the palpebral aperture, and are unprotected by the lids. I have frequently met with this affection in persons who have long resided in hot climates, especially in several natives of West India.*

Swanzy.—The starting point of a pterygium is generally an ulcer at the margin of the cornea, which, in healing, catches a morsel of the limbus conjunctivæ, and draws it towards the cicatrix, throwing the mucous membrane into a triangular fold. The ulcer then forms anew on the cornea immediately inside the cicatrix, and in healing the point of conjunctiva is drawn into it again, and is carried a little further into the cornea, and so on. Pterygium is a very rare affection in this country, but is more common in countries or localities where the air is filled with white sand, or other minute particles.

Wecker says the portion of ocular conjunctiva which is exposed to the air during the time the eyes are open, is its favourable seat.

Williams says pterygium is most commonly found in those exposed to the vicissitudes of the weather, *especially among seamen who have been much in warm latitudes.*

Wintner attributes pterygium to a thrombosis, causing obliteration of, or contraction in, either a corneal vein or one of the venal vorticosæ, which induces a disturbance of the circulation in the region of the cornea, supplied by the corresponding artery, proceeding along and penetrating the tendon of the adjoining rectus muscle.

Wolfe says, "This affection is generally considered to be the result of chronic inflammation of the ocular conjunctiva, but I cannot admit the accuracy of this view, having found that most of the patients who are thus affected have never had conjunctiva. *It is not common in this country (Scotland) and occurs mostly in foreigners who have been a long time in warm countries, furnacemen and blacksmiths are also liable to it.*"

The authorities agree in attributing pinguecula to the irritating action of substances, such

as dust, sand, and chemical vapors, but pterygium is attributed to—

The lax condition of the conjunctiva in persons over middle age by				5 writers
Chronic inflammation by				3 writers
Ulceration or abrasions				5 writers
Action of foreign bodies				6 writers
Exposure in hot climates				7 writers
Not due to any inflammation				2 writers
To pre-existing pinguecula				1 writer
Thrombosis				1 writer

In my note-book I find—

Number of cases				65
Male				41
Female				24
Average age				35
Range of age				9 to 74

The age applies to the time at which the cases were seen, not the age at which the pterygium may have commenced to form.

Deducting the extreme ages of 20 and under, and 60 and over, the average amounts to less than 35 years. Of the 65 cases, 14 had eye trouble previously, 46 had never suffered, and in 5 cases previous mischief was not noted; but no signs of inflammation or ulceration were found. It is difficult to understand how pterygium and pinguecula can be due to the same causes, though the two may exist together.

Conclusions.—I have never seen a pterygium under which a probe could be passed entirely without rupture of tissue, nor a pterygium in an eye which showed any trace of ulceration or abrasion of the cornea. My notes include 9 cases of pinguecula, in 5 of which traces of ulceration of the neighbouring cornea occurs. Not a single pterygium was found in the aborigines examined, but a half-cast girl of about 10 years old belonging to the same camp had a small pterygium on her left eye.

I have never seen a pterygium on the unexposed part of the eye; have only once seen it in a case of chronic granular lids; have noticed that the majority of pterygia advance during the summer, and remain stationary during the winter months.

I attribute pterygium entirely to a thickening of normal tissue in nature's effort to counteract the influences of a rapid evaporation from eyes much exposed to a hot, dry atmosphere; its frequency at the nasal side, to a greater amount of moisture being rapidly evaporated in the proximity of the puncta; and its lesser frequency at the temporal side of the exposed conjunctiva, to a lesser degree of moisture and evaporation at that part, and think that it begins in the conjunctiva, because the epithelium there is looser and more vascular than on the cornea; that the shape depends upon the radiating distribution of the conjunctival vessels, which the enlargement draws into its fold.

PROCEEDINGS OF SOCIETIES.

SOUTH AUSTRALIAN BRANCH, BRITISH MEDICAL ASSOCIATION.

THE usual Monthly Meeting was held at the Adelaide Hospital on Thursday, March 29, 1888.

Present:—The President (Dr. Davies Thomas), Professor Watson, Drs. Cawley, Gardner, London, Poulton, Todd, Verco, A. Wigg, H. Wigg, Messrs. Aitken, Olinde, A. A. Hamilton, Horneck, Jay, Lawrence, and the Hon. Sec. (Mr. Cleland).

The minutes of the meeting held February 23, 1888, were read and confirmed.

EXHIBITS.—DR. GARDNER showed three patients illustrative of his paper on Osteo-myelitis of the Tibia and its surgical treatment.

DR. TODD brought before the members a well-marked case of facial paralysis after exposure to cold.

REMARKS ON SOME PATHOLOGICAL SPECIMENS, EXHIBITED BY PROFESSOR WATSON.

I. *Multiple secondary perivascular carcinoma* in the bones of a miner set. 48, in whom the more immediate cause of death was a suppurative nephritis, following on retention and self-catheterisation.

Patient came to Adelaide from Broken Hill to be treated for lead-poisoning, and died within a few days of his arrival.

At the *post-mortem* examination, a flat and sessile epithelioma of the trigonum vesicæ, encroaching somewhat on the prostatic portion of the urethra was discovered. At the same time there were two or three marble-sized secondary deposits in the liver, as also a sprinkling of sago-like nodules interspersed with minute scattered abscesses in the kidneys. The spleen was large and diffident, but showed no deposits. The lymphatic glands throughout the body were unaltered. Both the pulmonary and costal pleuræ were dotted with flat, white patches, suggestive of the droppings from a composition candle.

After maceration, the ribs, vertebrae, pelvis, skull and jaws were seen to be the seat of wide-spread periosteal proliferation in the form of out-crops of spray-like, bony spiculae, which, in the case of the skull and jaws are particularly delicate and fine. The dentition is conspicuously good, but some of the teeth are beginning to undergo a certain amount of upheaval from their sockets. The right radius and clavicle, in addition to showing some slight incipient periosteal changes are the seat of old and very firmly united fractures, having no connection with present condition.

Had it not been for the presence of a primary vesical carcinoma, with sequential deposits in other soft parts, revealed by the *post-mortem* and microscope, the question of a general periosteal hyperactivity, incident on some obscure mineral intoxication, peculiar or not to the Barrier Ranges, might have suggested itself, analogous, in fact, to that condition of bony production noticed in cows after such animals have inadvertently been submitted to an arseniferous diet, or to the phosphorous periostitis of match manufacturers in the old world.

II. (a) *Left femur* of a negro of huge proportions, who, during life, was cook aboard an American whale-ship.

The femur shows a firmly united fracture at junction of middle and upper thirds of its shaft. The deformity is exaggerated as the fragments are united at an angle of 50° from their axis; a result in which the captain or the ship's carpenter probably played an active part.

(b) Skull of same individual; DR. VERCO called attention to a marked asymmetry of the base. The superior maxilla presents a typical example of abscess of the antrum of Highmore, induced by disease of 2nd upper molar and accompanying caries of alveolar process. The fangs in the rest of his head are sound.

III. *Membranous* cast of trachea and bronchi, coughed out of tracheotomy wound during the operation, by a girl of 15, who succumbed next day.

BALLOT—Robert H. Marten, M.B. Cantab., and Harry Swift, M.D. Cantab., were duly elected members of the British Medical Association and of its S. A. Branch. The following paper was then read:—

NOTES OF SOME CASES ILLUSTRATIVE OF THE INCUBATION PERIOD OF MEASLES.

By J. C. VERCO, M.D., F.R.C.S., &c., &c.

I BRING before the Association this evening some incidents in a limited outbreak of Measles in the Colony of South Australia in 1887.

A boy, M.T., aged 6½ years, came to Adelaide from Kensington, a suburb of Melbourne, Victoria, by train. He arrived here on August 4. On the morning of this day it was noticed that he had a cough and symptoms of a cold, supposed to be due to exposure during the railway journey. On the afternoon of August 7, while at the Exhibition, spots appeared on his face; and when seen the next day at noon, he had all the symptoms of a rather severe case of measles. His disease ran an ordinary course, save that the rash proper became petechial, and the petechiæ remained many days after the fever and the essential eruption had disappeared. Though, when leaving Melbourne, the lad's father had no knowledge of any infectious complaint prevalent in the vicinity of his house; when he had been in Adelaide a week, he received news that the neighbourhood was over-run by the measles.

On August 21 I was called in to see a boy, C.V., and found him in bed with the measles. The spots had been first noticed on the morning of that day, but he had had a cold, with cough, for three or four days. It appeared that the first lad, M.T., who stayed at Mitcham, had, on the day after arrival in the colony, called at the house of C.V., and stayed there an hour or two; though he was rather dull owing to his premonitory catarrh. This was on August 5. There was no other intercourse between the children.

On August 20 four children came from Salisbury to the house of C.V., and stayed till mid-day of the 21st. On this day his spots were first noticed, so they returned home immediately.

On September 1 one of these developed a few measles spots, and on September 3 the others began also to have the eruption. All had the typical disease, and it did not spread beyond the family.

From these cases, the extreme infectiousness of Rubeola is manifest. Though the first patient was in the house of the second as long as from one to two hours, yet they were said to be in one another's company only a few minutes, for the sickening child was dull and listless, and so the other went off out of the house to play alone.

In the next place, measles is demonstrated to be highly infectious during the catarrhal stage, and that too, at a very early period; for the second child was contaminated by the first three full days before any rash was noticed on his skin, and only one day after he had begun to suffer from the cough.

Lastly, we have here an excellent opportunity of calculating the duration of the period of incubation. The first child visited the second on August 5, the second had the measles spots on the face on August 21; so that sixteen days elapsed between exposure to infection and the appearance of the eruption. In the case of the second family, the interval was from August 20-21 to September 1, that is 12 days or 11 days in the one child, and to September 3, or 14-18 days in the other three. The incubation period, therefore, is thus proved to vary somewhat, under circumstances almost exactly similar, from 12 to 16 days. Two possible explanations suggest themselves:—First, the longer interval of 16 days may have been due to exposure to infection at the *early* stage of catarrh; the 11 or 14 days to exposure just *before* or just *after* the appearance of the *eruption*; in which case the law would be, "During the premonitory stage, the nearer the eruption, the shorter the incubation after exposure," or, secondly, the long incubation in the first instance may have been due to the short period of exposure, probably only a few minutes; and the short incubation to a much longer exposure; for the second family were 24 hours in the company of No. 2, and slept in the same room. In these instances the *severity* of the contaminating case did not appear to rule the duration of incubation; for the first case was the most severe, and was followed by the long incubation, the second case was extremely mild, and was followed by shorter periods.

I may, perhaps, be allowed to quote from Bristowe, as follows:—"The latent period of measles varies like that of all other similar diseases; its extreme limits are probably seven and twenty-one days. When the disease has been given by inoculation with the nasal mucus, the first symptoms are said to have manifested themselves on the seventh or eighth day. But when it is caught in the usual way by inhalation of the virus, the incubative period is generally from twelve to fourteen days." Ours, therefore,

were somewhat longer than the average, though well within the extreme limit of 21 days.

DR. DAVIES THOMAS pointed out that practitioners here, in Australia, enjoy exceptional opportunities of accurately determining various points in connection with disease, as compared with their fellow practitioners in the more densely populated countries of Europe. And this is especially the case in such a matter as studying the incubation period of some of the infectious fevers. He thanked Dr. Verco for having made such a very accurate record respecting the cases of measles just alluded to. The cases further illustrated very clearly that the mode of access of the infection plays an important part in determining the period of incubation. This fact is also seen in other diseases, such as hydrophobia. He thought Australians might yet have the honor of settling some doubtful points in connection with such matters.

MR. JAY read the following notes on the treatment of diabetes with codeina :

THE TREATMENT OF DIABETES WITH CODEINE.

BY MELVILLE JAY, M.R.C.S. ENG., ET
L.R.C.P. LOND.

I HAD hoped to have been present at the last meeting of this Society, to have recorded the following case in conjunction with Dr. Cleland's on the same subject. After seemingly a thorough trial of codeine, in large doses, in a case of polyuria or diabetes insipidus, Dr. Cleland concluded that this drug had little or no effect in reducing the quantity of urine eliminated, but I think the following history will plainly prove that in some cases of polyuria it has a well-marked effect.

Mrs. T., married, aged 37, no children. Health fairly good up to 26 years of age, at which time she noticed a great increase in the amount of urine passed; either immediately preceding, or simultaneously, with this event she suddenly ceased menstruating and she has never had any return of her menses since that time.

Dr. McIntyre, who then attended her, said she was suffering from diabetes mellitus; the average amount of urine then passed was thirty-two pints in twenty-four hours. She remained in this condition for two years, when she was told by the same medical man that no trace of sugar could be found in the urine. Since that time she has been treated by various medical men, but the daily quantity of urine has never decreased below fifteen pints, the average being from twenty to twenty-four pints, without any return of sugar.

I was called to see her for the first time at the beginning of this year. Found her suffering from severe hemicrania, which she informed me attacked her periodically. She was stout and flabby, complexion pale and waxy, eyelids puffy; in fact, her general appearance was suggestive of kidney

disease. She was then passing from eighteen to twenty pints of urine in twenty-four hours. On examination of urine found no trace either of sugar or albumen, spec. grav. 1003, no casts; no swelling of feet. Great tenderness of posterior wall of vagina and well-marked vaginismus, which had prevented her having intercourse for the past four years. Uterus small, but healthy. She was inclined at times to be hysterical. No symptoms of tuberculosis.

I commenced by giving her a pill three times a day containing a quarter of a grain of codeine, and half-a-grain of extract of nux vomica. On the second day after commencing this treatment the quantity of urine was diminished to nine and a-half pints, on the third day to six pints, and on the fourth day to four and a-half pints.

For two months after this she continued the same treatment, gradually increasing the amount of codeine to one grain three times a day; the daily amount of urine passed varied from four to six pints, never exceeding the latter quantity. She then ceased taking the medicine for a few days, with the result that the quantity increased to eight pints, but was again reduced to five pints on returning to the codeine. I have purposely not increased the dose of the drug to any great extent, as in this particular case it might not be advisable to reduce the quantity of urine too rapidly, and the smaller doses have so far acted so satisfactorily.

I think there can be no doubt that the cause of the abnormal increase in the amount of urine in this case and in that related by Dr. Cleland must have been widely different, or why should the drug codeine have so marked an effect in the one case and so little in the other? Roughly, I think we might assume from the prevailing symptoms in the two cases, that in Dr. Cleland's patient the polyuria was of cerebral origin, and in the case I have just related it was intimately connected with the distinct premature cessation of the menses, which occurred simultaneously with the sudden increase in the amount of urine.

In this way I think we may account for the drug acting so differently in the two cases. It would be well worth collecting a number of cases both of diabetes mellitus and insipidus, and where possible ascertaining the cause of the disease, and the effect of codeine upon the different cases.

I might mention that I have at present under observation a gentleman of 70, who is subject to attacks of diabetes mellitus, which invariably give way to treatment by codeine, the sugar completely disappearing, and the amount of urine returning to the normal, without any particular dietetic treatment.

His attacks are generally caused by the too free

use of alcohol, which he partakes of by fits and starts. The sugar does not show a tendency to decrease in amount until the exhibition of codeine.

DR. VERCO thought that the case referred to had consulted him at one time. He remembered that he had used valerian extensively in the case, but without producing any effect in diminishing the amount of urine passed daily.

DR. LENDON referred to a paper* he read on the same subject some two years ago, in which he narrated cases both of diabetes mellitus and diabetes insipidus, treated by codeine. He attributed the results obtained with this drug entirely to its action on the nervous system.

DR. A. HAMILTON made some remarks and related the following case: T. W. set. 56, labourer. Spare figure. Always healthy till the middle of December, 1887, then began to pass water with unusual frequency, sometimes as often as every 15 or 20 minutes. First seen on February 24, 1888, passing then about 480 ozs. per diem. Water clear, faintly acid, no albumen or sugar. Sp. gr. 1008, ordered codeine, gr. i, t.d. March 20—average, 240 ozs.; March 27—average, 160 ozs. During the last week he has complained much of vomiting. Whether this is due to the drug or not I have not as yet ascertained. No alteration was made in his diet, the sole treatment so far being the administration of codeine as above. He is still under observation.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE adjourned annual meeting of the New South Wales branch of the British Medical Association was held at the Royal Society's Rooms, Elizabeth-street, Sydney, on Friday, April 6, 1888, at 8 p.m.

Present: The Hon. J. M. Creed, M.L.C., in the chair, Drs. Knaggs, O'Reilly, Chambers, Roth, Garrett, Twynam, West, Kendall, Wm. Chisholm, Crago, Hankins, Worrall, Fiaschi, Faithfull, Martin, Foreman, Clubbe, and Scot-Skirving.

The Hon. J. Mildred Creed, the retiring President, delivered the following

PRESIDENTIAL ADDRESS.

Gentlemen,—It is now my duty, as the retiring President, to address you, and to review in a brief manner some of the more important events, that have special interest to this Association which have taken place during my year of office. In the first place I have to congratulate the Society on its satisfactory position, not only pecuniarily, but also on account of the increase in its roll of members, and of the constant and lively interest shown in its proceedings. This interest has not been confined to the members only, but has been evinced by the public of the colony, and even by illustrious men in the old country. As evidence of this I may mention the kindly letter which, as editor of the *Australasian Medical Gazette*, I received from Sir Morell Mackenzie, in which he expresses the interest which he had felt in reading Dr. Scot-Skirving's paper on tracheotomy, with the discussion which followed. In this letter he expressed his concurrence with the views of the author and our fellow members, except so far as related to the use of anæsthetics for the operation, and by the accounts recently received we see how

* *Australasian Medical Gazette*, Vol. V., p. 188.

strongly he expressed a similar opinion in relation to their use under the same circumstances, in the case of his illustrious patient, the Emperor of Germany.

Our very satisfactory monetary position is the result, in a great measure of the time and care devoted by our Honorary Treasurer, Mr. Hankins, to the duties of his office, and our gratitude is also due to the Honorary Secretary, Dr. Scot-Skirving, and to the Assistant Secretary, Mr. Green, for the devotion and exactitude which they have shown in the conduct of business.

Papers have been read on a Case of Stomatitis with Jaundice, by Dr. F. H. Quaife; Landry's Paralysis, by Dr. Jarvie Hood; Aphasia, following Fracture of the Skull, by Dr. Asher; Obstruction of Stenson's Duct, by Dr. Scot-Skirving; Lance Wound of Abdominal Wall, with Strangulated Hernia, by Dr. Newmarch; Uræmia, Dr. Kendall; Osteotomy for Bent Tibia, by Dr. Clubbe; Thyroidectomy, by Dr. Twynam; Tracheotomy, by Dr. Scot-Skirving; Hydatids in Bone, by Dr. Leacock; Ligature of Subclavian Artery for Axillary Aneurism and Ablation of the Male Genital Organs, by Dr. Hankins; Diabetic Coma, Dr. Crago; On Digestive Ferments, with demonstrations, by Dr. McCormick; a paper was also read by Dr. Clubbe on The Position of the Profession in Relation to Friendly Societies, an interesting discussion arising, which was followed by a general meeting of the profession.

We have to deplore the deaths of five members of the Society, viz., Drs. Hoff, Halket, Lentaigne, Markey, and Leacock, the sympathy of the association having been conveyed to their representatives.

The year in the life of the Association, which has now terminated, has been an eventful one in the history of medicine in this country, for during its passage several events have occurred of vital interest to our profession. The first which I will mention is that since our last annual meeting six students have completed their professional education at the University of Sydney, and have obtained their degree of M.B. These gentlemen are the first who have obtained this distinction as the result of education received at our local medical school, and their graduation is, therefore, a memorable event.

On August 30th last the first Medical Congress which ever was held in the southern hemisphere met in Adelaide, South Australia, under the presidency of Dr. Verco, a native of that colony. Medical men from all the Australasian colonies were present, the papers read were of a high character, and the discussions following eminently useful. The Congress received the kindly sympathy of the various Governors and Governments, and the members were most cordially received and hospitably entertained by the people of Adelaide during their visit. This Congress is the first of what, it is to be hoped, will be a successful series of meetings of a similar character, to be held from time to time in the capitals of the various colonies, and it has been decided that the next shall take place in Melbourne. It was thought best that meetings of the Congress should not be held too frequently, but that sufficient time should be left between each to allow of practical and systematic enquiry, so that worthy papers, relating to original research might be prepared, and that the proceedings should be worthy of the occasion. The President-elect for it is that surgeon of world-wide fame, Mr. T. N. Fitzgerald. Though three years was the period which it was suggested should elapse before the meeting of the next Congress, the exact time was left to be finally fixed by the medical societies of Victoria, as it was felt that the present being the centenary year of Australian colonisation, and the fact that an International Exhibition was to be held in Melbourne during the current year, might render it advisable that the meeting should

take place during the time it was open. As a consequence it has been proposed that next January be the time, and I am the bearer of the cordial invitation of the President to the profession in this colony to join in the good work. A more formal communication will be sent shortly.

Since the last annual meeting, a Select Committee, appointed by the Legislative Council, to enquire into the state and operation of the laws for the regulation of the practice of medicine and surgery in New South Wales has made its final report, which has been adopted unanimously by that House of Parliament. The principle upon which the enquiry was conducted was that only evidence as to matters of fact should be taken, and that nothing which could be a matter of opinion should be received. Acting on this rule, a number of persons who practised medicine without possessing qualifications recognised as sufficient by the Medical Board of New South Wales, were examined and gave an account of the opportunities they had had for professional training. All will remember the startling character of the revelations made in the information given before the committee, and this notwithstanding that all evidence of the evils which had resulted in particular cases by the professed treatment of these ignorant men was rigidly excluded, as it was felt by the committee that the treatment of every case must of necessity be a matter of opinion, the value of which would depend on the character of the individual giving it, his mental capacity, and the opportunities he had had for acquiring professional knowledge. The report stated that practically there were no laws regulating medical and surgical practice in this colony, that there were a very large number of grossly ignorant men practising medicine to the peril of the credulous or ignorant public, and that though there is a register on which the names of duly qualified men are placed, that there are some names included in it which had been placed there by fraud, or by the presentation of what had subsequently been found to be valueless diplomas but that any name having been once placed on the list there was no legal means of removing it. To remedy this state of things, it was recommended that the Medical Board should be reconstituted, that it should have greater powers, be able to suspend its judgment by registering applicants provisionally, and that in cases of misrepresentation or misconduct on the part of a registered practitioner, to remove his name from the register, either for a time or absolutely, as the nature of his misconduct rendered necessary. The committee called attention to the danger of accepting the evidence of unqualified practitioners as expert witnesses in criminal cases. It was not prepared to recommend that any person should be prevented from practising medicine, but it earnestly pressed the absolute necessity of preventing any man not registered as a medical practitioner assuming a title which might deceive members of the public into believing that he possessed fitting diplomas. It also recommended that everyone practising medicine should have to place upon the house in which he carried on his practice a notification of his name and that he is a practitioner of medicine, and that those persons who practise without being registered should add, "Unregistered by the Medical Board." I think that by these means all that is practicable for the protection of the public would be accomplished, and that when such provisions become law, any person who consults an untrained man, practising as a medical practitioner, will do so with his eyes open, and will neither deserve or receive sympathy in any trouble or physical injury which may follow as a consequence of his folly. The 24th section of the report expresses the opinion "that

the evils are so grave, and of such vast moment to the whole population, that it is urgently necessary that legislative action for their remedy should be promptly taken, and that any bill for the purpose should be introduced by the Government." Action by the Government was also pressed upon the Premier by a letter, in September last, signed by Sir Alfred Stephen (Lieut. Governor), Sir Frederick Darley (Chief Justice), His Eminence Cardinal Moran, The Primate (The Right Rev. Dr. Barry), the heads of all the other religious sects, the Mayor of Sydney, and the President of the Chamber of Commerce. A more thoroughly representative body of men it would be almost impossible to conceive, and these gentlemen all expressed their hearty sympathy, and said that they believed they would leave a duty unfulfilled did they not press the necessity for Legislative action on the Premier and his colleagues. I am still of the opinion, which I have often expressed, that it is not advisable that a bill should be introduced into Parliament by any private member, and that in no event should it be done by a medical man holding a seat; this opinion, I think, has been endorsed by the majority of yourselves. One member of the Branch, it seems, thought differently, and, in spite of all protest, persisted in introducing a medical bill of very limited scope, in no way fulfilling the conditions thought necessary by the Select Committee who had the best opportunity of deciding what was required. Six months having passed, this measure is only in its initial stage, which it is not likely to get beyond before the session closes. This isolated action is the more to be deprecated, as it furnished the Government with a legitimate excuse for inaction, and as yet nothing has been done by it. I may here say that, as chairman of this committee, I have been complimented by the special enmity of many of the men whose ignorance and nefarious conduct has been exposed by it, and I have in my possession a very large number of threatening and abusive anonymous letters. Some of these are the offspring of such filthy minds as to be almost unreadable, and they all are so evidently the outpouring of impotent malice as to need no action for the punishment of the senders, who could, however, in most instances, be traced. In contrast to these letters I would mention the receipt of many times their number of others of an entirely opposite character from persons in all parts of the colony who have been victims to quacks, thanking the committee for so efficiently fulfilling its mission, which was to place before the public incontrovertible evidence of the evils from which its members suffer, in such a way that the Press might make comments without fear of actions for libel.

The defective state of the law in this colony for the registration of births, marriages, and deaths was pointed out by another Select Committee of the Legislative Council, which sat in 1886, and its report was unanimously adopted by that House during the last session of Parliament. In a matter of such public importance, it would be more fitting that reform should be brought about by the action of the Government, but it soon became evident that the present one was apparently indifferent to the matter, and that it is unable to fulfil half the promises made in His Excellency's Speech on the opening of the session. This being the case, I considered it my duty as the chairman of the committee to endeavour to give effect to its recommendations, and I accordingly have introduced a bill into the Legislative Council for the purpose. In it provision is made for the registration of the birth of a child at any time, proper precautions being taken, and fitting penalties for neglect inflicted. Under the present Act the birth of a child not registered before it is six months old can not be registered at all. A record

is also to be kept of all still births, and of the disposal of the bodies of the resulting children. Extensive alterations are proposed in the registration of deaths. By the present Act no certificate as to the cause of death is required, though such certificates are accepted by the Registrar-General and his subordinates from anybody. In the evidence given by this officer it was admitted that certificates had been accepted as all sufficient from most ignorant men, in fact, that he had directed that they should be received from anybody, and he made the extraordinary statement that he had directed his subordinates to receive them from any man who called himself a homœopathist, utterly indifferent as to whether the man had any recognised qualification, or had received any medical training. Such conduct cannot fail to be conducive to crimes against life by the facilities which it gives for their concealment, and a more extraordinary statement was probably never made by a public officer occupying such a responsible position as Registrar-General. The bill provides that the district registrar shall demand a certificate of identification of the body from a person who has known the deceased during life, also a certificate as to the cause of death from a legally qualified medical practitioner, if one has been in attendance, if not, one from a police officer of the district in which the death occurred, that he had made enquiry and found no reason to think that the death had occurred from other than natural causes. On the production of these certificates the registrar is directed to register the death, and to issue a permit for the burial or cremation of the body, directed to the person in charge of the cemetery or crematorium chosen by the friends. No burial is allowed to take place until after the registration of the death and the issue of this permit, except in some few cases, such as occur in remote country districts, for which special provision is made. Managers of the cemeteries or crematoria are required to keep a register of the bodies disposed of by them, and are required to furnish a periodical report of all of them to the Registrar-General, and to the registrar issuing the permit. Under the present Act a body may be disposed of before the death is registered, which may be done at any time before thirty days have elapsed after the event. No public record is kept by the cemetery authorities, and the burial is only required to be reported by the undertaker, who may be an irresponsible person, who can neglect to comply with the regulations with impunity.

Like my predecessors in the office of President, I feel it impossible to pass without notice the constant peril the colony lies under with regard to the introduction of small-pox. A few years since it was only occasionally that a ship arrived having had an outbreak of the disease on board, but now our quarantine station is rarely free, and it sometimes happens that a fresh ship arrives with it on board before the crew and passengers of previous ones have been released. With the present rapidity of transit the voyages are rendered so short that the risk of the introduction of this terrible disease amongst an unvaccinated population is immeasurably greater than it was but a few years since. It is true that hitherto our admirable health authorities have been able to completely isolate all cases, and so have been successful in stamping out each outbreak, but this good fortune it would be absurd to expect always, and sooner or later the type of the disease introduced will be of so virulent a character that it will spread like wildfire, and the number of the infected houses will quickly become so great as to render isolation impossible, when nothing but universal vaccination and re-vaccination will prevent the disease from becoming endemic to the continent. The terrible

neglect of vaccination in New South Wales is absolutely appalling to the trained and unprejudiced mind. It being left to the discretion of the people but a very small proportion of the children are vaccinated, some parents objecting through groundless fears produced by rash or prejudiced statements made by persons without justifiable grounds for the confident assertions they make of the evils said to have resulted from vaccination. Cases are quoted in which troubles of more or less serious character are said to have followed the operation, but no proof is adduced that they were consequent on it. I think the only way to effectually combat the great public danger of these unfounded beliefs would be by the establishment of a commission, who would sit for a time to receive the fullest information that could be brought as to the evils said to have resulted from vaccination in Australasia, nearly or quite all of which are chimerical, and make searching enquiry into the facts of every case. In this way we should have some positive record of what danger really exists, and should not be continually confronted with reckless statements unsupported by anything but mere assertion. I may say that I made this recommendation in the Legislative Council in 1886, and it was favourably received by the Right Honourable W. B. Dalley, then representing the Government in that Chamber.

The question of Federal Quarantine is still in abeyance, and though the scheme formulated by the Hon. Dr. Mackellar was adopted by the Australasian Sanitary Conference which met in this city in September, 1884, nothing beyond mere talk has yet resulted. The varying action by the different colonies in relation to quarantine is much to be deprecated, as tending to unnecessarily hamper commerce, and as productive of undue risk of the introduction of disease. Undoubtedly the persons infected should be removed, and the ship disinfected at the first port of call, instead of, as is too often the case, being left on board the vessel until it arrives at its destination. In this way time would be saved, the safety of the crew and passengers on board would be properly studied, and unnecessary expenditure avoided. The disease which renders quarantine most necessary at present is small-pox, but sooner or later this disease will be over-shadowed by cholera or yellow fever, whose introduction is much more to be dreaded, and whose appearance on our shores can be but a question of time.

Intimately connected with this question is that of cremation, for it would be a great sanitary precaution could we ensure the destruction by fire of the bodies of all persons dying from these diseases, instead of by burying them, hoarding up a store of germs to be brought into activity at some future time. The proposal to provide facilities for the disposal by fire of the bodies of persons dying in quarantine from these diseases was made by the principal medical officer (Dr. MacLaurin) at the time of the outbreak of cholera on board the mail ship "Dorunda" in Queensland waters, but this admirable suggestion has had no practical result.

A bill regulating the process of cremation has twice passed the Legislative Council, but on each occasion failed to come up for discussion in the Assembly, the conduct of business in that chamber being such that the passage of a bill of any great public interest, such as this is, when introduced by a private member, has become almost impossible. The bill was opposed by the persons averse to cremation, who, however, had they acted in a logical manner, should have supported it as tending to provide proper precautions against abuse in the conduct of a system which those in favour of it have every right to use. This means of disposing of the dead is

quite legal at the present time, and at a meeting held in this room some time since, the preliminary steps were taken for the institution of a Cremation Society, which will shortly have practical effect.

A question of vast moment to the people of these colonies, which should be of great interest to the members of this association, is the use of disease for the destruction of rabbits. The peril to the general prosperity by the enormous increase of these animals is so tremendous, and has proved itself so uncontrollable by all the ordinary means of destruction hitherto adopted, that men's minds have naturally turned to some means outside the ordinary lines for their deliverance. The first public proposal in this direction of a practical character was made, at my suggestion, in March 1883, and since that time I have persistently pressed the necessity for such inquiry as would ascertain full particulars of all outbreaks of disease fatal to rabbits in any part of the world, and also that specially qualified men should be appointed to conduct exact experiments in the districts, and as far as possible under the circumstances, where the disease will have to be used. Had these proposals been acted on, we should now have a great deal of evidence of a positive character, which would have enabled the various Governments to have arrived at a decision. As it is, we know nothing on the subject, and the meeting of the proposed Intercolonial Conference, which is shortly to take place, will I fear have no practical result. The question to be considered is essentially a pathological one, but it is so out of the usual track that the previous pathological experience of those gentlemen forming it who are pathologists will be of comparative inutility. Besides, its composition, if as reported in the newspapers, is of so heterogeneous a character that it is hardly possible that its meeting can lead to any real good. But, even supposing it was the most suitably constituted body in the world, there is no evidence to place before it except that of the gentlemen who have made proposals as to the use of certain diseases for the destruction of rabbits, and are applicants, as a consequence, for the reward of £25,000 offered by the New South Wales Government. There can be but little doubt but that these gentlemen will only state with regard to their proposed diseases what they believe to be absolute facts and probabilities, but what knowledge will the members of the conference have to traverse their statements? It might be said that this conference in its corporate capacity could employ subordinates to make experiments, and that on these it could frame its report and recommendations. I think, however, you will agree with me that such a division of responsibility would be a public danger, and that those making the report should also be personally responsible for the accuracy of the experiments.

Up to the present time the propositions made to the New South Wales Government for the use of disease against rabbits are, that of M. Pasteur by their infection by chicken cholera, a malady already present amongst the poultry of Australia; the rabbit scab (*sarcoptes cuniculi*) by Professor Watson, of Adelaide; and the disease which spontaneously broke out on the Tintinallong station on the Darling River, the pathology of which is being carefully studied by Drs. Ellis and Butcher. It is certain, however, that other diseases will be proposed, and it is equally certain that it will not be by one disease only that our deliverance will be brought about, but that at varying times and places and under diverse circumstances different diseases will have to be used. In a thickly-infested district one rapid in its course will be most suitable, whilst in another, with fewer rabbits, one much slower in its effects will be most useful, for days might pass without the animals coming into contact to infect

each other. It will also probably be found that a disease highly destructive at first will become less so after a time and the work will have to be continued with some other, whilst an epidemic which in one district near the coast may be very destructive will prove valueless in the dry interior. Neither the Governments or the people of Australia have really any choice as to whether disease shall be used or not, for, in spite of everything, pastoralists threatened with ruin will make use of it, despairing as they are of success by any other means. In South Australia, and in the Western districts of this colony and of Queensland, runholders are freely expressing their intention of using disease in spite of any legislation to the contrary, and they also say that they will not even wait for the decision of the conference, if it is not arrived at more quickly than they think it probably will be. What the Governments only have a choice in is, whether the use of disease shall be properly supervised and the results recorded for general use, or whether rash and ignorant efforts shall be left uncontrolled and with no record of their effects, unless they are of so dangerous a character as to have created public alarm. If a competent body were created, whose duty it should be to acquire and disseminate accurate information, no reasonable person would act on his own insufficient knowledge, the sympathy of the people would be with the authorities, and any action taken by them to coerce rash men into proper caution would receive the support of the neighbouring runholders and of the people generally. By adopting the one course we shall have the greatest risk with the least benefit, instead of as by the other the greatest benefit at the least risk.

A notable event of this year has been the dedication by Mr. W. H. Paling, of this city, of an estate near Camden, containing 450 acres, for a convalescent station; this generous gift he has also supplemented by the addition of £10,000 towards its endowment. Such munificent generosity commands the highest eulogy from the fellow-colonists of the donors, for it must not be forgotten that a legacy of £100,000 and land for a site was left by the late Mr. Thomas Walker, of Concord, for a similar purpose, and that convalescent homes have for some time been in existence, having been created and carried on at the cost of the generous liberality of Miss Mort and Colonel Goodlet respectively. Whilst fully acknowledging the generosity of these gentlemen and this lady, I do not think it will be out of place if I point out what is too often overlooked by the public in general, viz: the generous devotion of many of our fellow medical men whose professional services are so freely given to the sick poor when fulfilling the duties of the honorary offices which they hold in the various hospitals and other public institutions. The money value of these services is but little realised by the lay public, for the duties, though so onerous, are carried out so thoroughly and unostentatiously as to but rarely excite the attention and acknowledgment which are their due. By a calculation carefully made, I am in a position to say that one gentleman in this city has given his services during the last four years to the amount of at least \$9,000, when the value of the operations he has performed gratuitously is calculated at the lowest rate of the fees he receives for them from his patients in private practice. In this calculation, only the operations have been made the basis, mere consultations, many hundreds in number, having been omitted. Nor is this generosity confined to gentlemen holding appointments, for there are but few practitioners who do not give professional services gratuitously to the value of several guineas per week.

A matter which is becoming of serious moment is

the disproportionate number of medical practitioners who are coming from all parts of the world for the purpose of settling in Australia with a view to practice. The hopes of many of these gentlemen are fated to disappointment, for the number of medical men in proportion to the population is rapidly becoming so large that remunerative practice can be but the reward of very few of them. In proof of this I would point out that whilst in England there is but one medical practitioner to every 1,562 inhabitants, in New South Wales there is more than one to every 1,250, if the men practising without qualifications be included in the calculation.

With regard to the medical literature of Australia, I may mention that a report of the proceedings of the first Australasian Medical Congress has been issued, and that it does credit to its compilers, who have exercised great judgment in their editorial duties. A book which will be of great use both to the profession and to the public has been recently published by Mr. Ludwig Bruck, who is also the author. It is entitled "The Health Resorts of Australia, Tasmania, and New Zealand." The information conveyed in it is very accurate and minute in its particulars, and it has received most complimentary reviews from the lay press.

The *Australasian Medical Gazette* is fully sustaining its character as a professional newspaper, and it circulates throughout the world, numerous papers being reprinted from it by the medical journals of all nations. The general interest felt in it by the profession in other countries is well exemplified by the fact that by recent mails I have received copies of Russian publications, seven numbers of which contained one or more papers reprinted from the *Gazette*.

In conclusion, I humbly proffer my hearty thanks to the members of the Association for the unvarying kindness they have displayed towards me during my term of office, and to assure them of my hearty appreciation of their sympathy and support. Though fully conscious of my shortcomings, I trust they will believe that I have done all that lay in my power to advance the well-being of the Association, the profession, and the public.

The Hon. J. M. Creed then left the chair, and the President-elect, Dr. Chambers, took the chair.

Dr. KNAGGS said he had much pleasure in proposing "a vote of thanks to Dr. Creed for his able address, and for the general interest displayed by him in the work of the branch." He (Dr. Knaggs) felt sure that, as mover for the committee which reported on the registration of births and deaths, Dr. Creed deserved the thanks of the whole community, for if the bill was properly administered many existing evils would be remedied, and then again with regard to the report of the committee on the law and practice of medicine Dr. Creed's action was to be commended by every right-thinking person.

Dr. CLUBBE seconded the resolution, and said that Dr. Creed's action in the matter of the registration of births and deaths would no doubt result in much good, as it would do away with many evils which exist at the present time. He (Dr. Clubbe) thought the certificate of death should be signed by a registered medical practitioner, and he hoped that the Bill would specify the length of time a medical man should be in attendance upon the patient before death before he could certify to the cause of death.

The Hon. J. M. CREED thanked the members for the vote of thanks, and for their appreciation of his actions in the performance of his public duty.

Dr. CHAMBERS thanked the members for the honor they had done him by electing him to the position of President. He (Dr. Chambers) felt the position to be

one of difficulty, especially in following such a good all round man as Dr. Creed. However, he would do his best, and he would ask members to lend a helping hand. They were entering upon a year of new work, and, besides, this being the centenary year of the colony, could not they as a branch do something to mark this year. He would, therefore, invite every member to make a special effort to help on the work of the branch. The Hon. Secretary would be glad to receive the names of any gentlemen who would undertake to read papers at the meetings.

The Hon. Secretary (Dr. SKIRVING) stated that he had received £102 8s. towards the Leacock Fund, and that the Newcastle committee wish to send in their contributions at the same time as this branch.

Dr. Scot-Skirving exhibited a curious specimen of surgical instrument made and used by an amateur.

The President announced the election of the following gentlemen:—Dr. Lloyd, of Hunter's Hill; and Dr. Robertson, in Auckland.

THE NEXT INTERCOLONIAL MEDICAL CONGRESS OF AUSTRALASIA.

THE second meeting of the Provisional Committee of the next Intercolonial Medical Congress, to be held in Melbourne, took place in the Hall of the Medical Society of Victoria, on March 13, Mr. T. N. Fitzgerald, F.R.C.S.I. (President-elect), in the chair.

ELECTION OF MEMBERS OF COMMITTEE.

The following gentlemen were elected members of the Provisional Committee:—Drs. Alsop, Balls-Headley, J. W. Barrett, A. Bennett, F. D. Bird, S. D. Bird, Bowen, Burke, W. H. Campbell, Carstairs, A. Colquhoun, J. Cooke, Surg.-Gen. Cunningham, Drs. R. B. Duncan, Duret, W. H. Embling, G. H. Fetherston, Fishbourne, Fleetwood, F. T. West Ford, T. Foster, T. M. Girdlestone, D. Grant, A. S. Gray, Professor Halford, Colin Henderson, T. Hewlett, W. Howitt, Jonasson, the Hon. Le Fevre, A. J. R. Lewellin, McCreery, McCrea, McInerney, McKee, Moloney, W. Moore, W. Morrison, Nicholson, O'Hara, Peipers, Pettigrew, Pincott, Pincock, Rankin, G. A. Reid, J. Robertson, C. S. Ryan, J. P. Ryan, D. Skinner, Beattie Smith, Charles Smith, S. Maberly Smith, Snowball, G. A. Syme, W. H. Syme, M. B. Thomson, W. B. Walsh, J. H. Webb, H. C. Wigg, Willmott, and Wooldridge.

DATE OF NEXT SESSION.

The President-Elect then submitted a special report concerning the advisability of re-considering the date of the Congress. He stated that numerous representations had been made to him by members of the profession, urban, suburban and country, to the effect that it was highly expedient that the Congress should assemble during the currency of the Centennial Exhibition, and he proceeded to detail the arguments in favor of this course.

A prolonged discussion ensued, and it was ultimately resolved that, as the Committee had been that evening greatly enlarged, it would be wise to submit the question to a full meeting.

Dr. NEILD accordingly gave notice that, at the next meeting of the Provisional Committee, he will move:—"That the former resolution, fixing the date of the Congress, be rescinded, and that the Congress be

held during the currency of the Centennial Exhibition, at such time as the Provisional Committee may now determine."

The remaining business, including the drafting of a circular to members of the profession, and the election of Associate Secretaries, was left for consideration at the next meeting.

THE Provisional Committee for the next session of the Intercolonial Medical Congress of Australasia met again in the hall of the Medical Society on March 22. There was a large and representative attendance. The President-elect, Mr. T. N. Fitzgerald, occupied the chair. Letters were read from several members regretting their inability to be present, and expressing their warm interest in the success of the congress.

THE PRESIDENT'S ADDRESS.

The PRESIDENT remarked that, as many members of the Committee were present for the first time, he would shortly state the history of the formation of the Committee and of its proceedings up to the present date. At the close of the first session of the Congress, held in Adelaide in August and September last, a special meeting was held to determine the place and date of the second session. It was unanimously agreed that the Congress should assemble in Melbourne, but there was some difference of opinion concerning the date. A general consensus of opinion prevailed that as a rule it would be a mistake for the Congress to meet more often than once in three years; but doubt was expressed whether the occurrence of the Centennial Exhibition in Melbourne in 1888-9 would not constitute a valid reason for departing from the general rule. Ultimately it was resolved that the Congress should re-assemble in Melbourne in 1890, or at such earlier time as the medical societies of Victoria might determine. A Provisional Committee was accordingly constituted by joint resolution of all the medical associations of Victoria, and was empowered to make all needful arrangements for the session until a meeting of enrolled members can be held, at which a progress report will be submitted. The Committee included representatives of the Medical Society of Victoria, the Victorian Branch of the British Medical Association, the Ballarat District Medical Society, and the Bendigo Medical Society, and had power to add to its numbers. At the first meeting of the Committee it was resolved that the next session should be held in 1890. Subsequently, however, in consequence of numerous urgent representations made to him by members of the profession, including urban, suburban, and country members, and by gentlemen of high position and great influence outside the profession, he (the President) brought the question of date again before the Provisional Committee, and it was evident that further consideration had led a large proportion of its members to the view that a great mistake would be made if the Congress were not held during the currency of the Centennial Exhibition. In the meantime the Committee had strengthened itself by adding to its numbers about 60 gentlemen, and had thus become far more fully representative of the profession throughout the colony. It was therefore determined to invite the full Committee, as now constituted, to determine afresh and finally when the Congress should be held.

DATE OF THE CONGRESS.

Dr. NEILD then moved, in accordance with notice that the former motion fixing the date of the Congress be rescinded, and that the Congress be held during the

currency of the Centennial Exhibition, at such time as Provisional Committee may now determine. Dr. Neild set forth fully the arguments in favor of this course, and indicated several disadvantages which would hinder the success of the Congress if held in 1890.

Dr. F. T. WEST FORD strongly supported the motion.

Dr. WHITCOMBE, as President of the Ballarat District Medical Society, said that the question was referred to at the last meeting of that Society, and the unanimous opinion was that the Congress should be held early in 1889, during the currency of the Exhibition.

A prolonged discussion followed, and ultimately the motion was carried by a large majority.

On the motion of Dr. MOLONEY it was then unanimously resolved that the Congress should assemble on Monday, January 7, 1889, and should rise on Saturday, January 12.

CIRCULAR TO MEDICAL PROFESSION.

The Hon. Secretary, Professor ALLEN, submitted a draft circular addressed to members of the profession throughout Australasia. On the motion of Dr. NEILD, seconded by Dr. FORD, the circular as drafted was unanimously adopted.

ASSOCIATE SECRETARIES.

The Hon. Secretary nominated Dr. G. A. SYME and Dr. J. W. BARRETT for appointment as Associate Secretaries. The nomination was confirmed on the motion of Dr. J. WILLIAMS, seconded by Dr. BROWNLESS.

FURTHER PROCEEDINGS.

Dr. BROWNLESS undertook to notify the change of the date of the Congress to the Executive Committee of the Centennial Exhibition. It was agreed that the circulars to members of the profession should issue without delay, and that a meeting of enrolled members of the Congress be held as soon as possible, when the Executive of the Congress will be finally appointed. The various sections will then be constituted, and the Presidents, Vice-Presidents, and Secretaries of the sections will be elected. Reference was also made to the necessity for early notification of papers and for the organisation of the more important discussions.

NOTE ON SHOTTED SUTURES.

COMMUNICATED BY MR. G. T. HANKINS, M.R.C.S.E.

PERFORATED shot are useful for clamping certain forms of wire sutures, but it is difficult to fix the shot whilst the hole is being bored. A special instrument is made for this purpose, but to those who do not possess such, or who do not wish to be at the expense of buying one, the following suggestion may be useful:—A small brass box-hinge should be selected, having at least one pair of screw holes, of suitable size, exactly corresponding on opposite plates of the hinge. A shot placed in one of the sunken holes is held firmly in position when the hinge is closed, and can be readily bored with a small awl. The burred edge can be cut off with a knife before the shot is released from its vice.

Sydney, March, 1888.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, APRIL 15, 1888.

EDITORIALS.

THE ASSOCIATION OF REGISTERED MEDICAL PRACTITIONERS OF SOUTH AUSTRALIA.

On the evening of April 8, a meeting of Medical Practitioners was held in Adelaide, to consider the formation of an Association of Legally Qualified Medical Practitioners, having for its object the mutual defence of the interests of the profession in South Australia. The meeting was well attended by leading practitioners, both from town and country.

Dr. Hayward was voted to the chair. A number of letters were read from gentlemen unable to attend, promising hearty co-operation and offering numerous suggestions.

It was unanimously determined to form such an association with the above object, over forty practitioners having given in their allegiance to the project.

Dr. Hayward was unanimously elected President of the Association, Dr. A. A. Lendon was elected Hon. Treasurer and Secretary. A ballot was taken for five members of Council, resulting in the election of the Hon. Allan Campbell, M.L.C., and Drs. Corbin, Hamilton, Jay, Popham.

It was then decided that the Council should take steps to arrange a conference with the Friendly Societies, to discuss various matters of mutual interest, including the scale of charges to be paid by members of lodges desiring medical attendance. A tariff was suggested to the Council as a basis of the negotiations.

The President in closing the meeting drew the attention of members to the various objects, which might profitably engage the consideration of the Association, and how in many ways its operation must inevitably tend to strengthen the hands of the profession generally.

We append an abstract of the report of the committee, together with the proposed tariff.

ABSTRACT OF REPORT.

Your Committee have considered the question remitted to them, viz., the advisability of forming an Association of Medical Practitioners, with the object of protecting their mutual interests, and also to report on the details of such a scheme. They are of opinion that the present relations of medical men to medical work in connection with lodges necessitates the existence of such an Association. They frankly express the opinion that it would be futile to coerce the liberty every medical man possesses to give his labor for such a reward as he deems it is worth, but they are equally clear in their conviction that voluntary concerted action among the profession on the point specially referred to would be greatly to the advantage of all.

It cannot be denied that the practice of tendering for medical work, not only in connection with lodges, but also in several public appointments, is a modern innovation, and is calculated to reflect seriously on the dignity of the profession, and destroy its prospects as a field for educated men to labor in. Your Committee confess that the competition which leads to advances in medical knowledge, increased skill, greater diligence and faithfulness in the discharge of responsible work is most praiseworthy; but the competition which merely results in the lessening of the pecuniary reward for the labor done is intrinsically bad. They feel, therefore, that great good could be accomplished by the formation of this Association, and they also feel that due tone and effective moral influence can only be secured to the Association by all members of the profession giving it their individual support. They are therefore of opinion that its membership should not be confined to those who have positions attached to lodges, but should extend to all registered practitioners. Your Committee would consequently urge upon every such practitioner the need of joining the Association, believing that nothing but injury of the most serious nature can arise from the way in which matters between medical men and lodges have been going for some years past.

The following, therefore, are the recommendations of your Committee:—

1. That an Association be formed to be called "The Association of Registered Medical Practitioners of South Australia."
2. That all medical practitioners duly registered in South Australia be eligible to become members of the Association.
3. That the subscription be one guinea, to be paid by each member on joining the Association. N.B.—This will do away with the necessity for collecting annual subscriptions.
4. That the sole object of the Association be the mutual defence of the interests of the profession in South Australia.
5. That the affairs of the Association be transacted by a President, Secretary and Treasurer, and Council of five other members, to be elected at the annual meeting of the Association.
6. That a conference be held with representatives of the various Friendly Societies in order to abolish the system of tendering, and to secure the adoption of some uniform tariff.
7. That an endeavor be made to enforce the rule that lodge surgeons should be duly registered.

Your Committee further suggest that country members should make their own terms with respect to dis-

tance with lodges. They also feel that many other points relating to the general welfare of the profession might from time to time be considered by the Council.

PROPOSED TARIFF.

In Single Lodges.—10s. per annum for adult single lodges, male or female; 6s. per annum the minimum for juvenile lodges, and membership to cease at the age of eighteen.

For Family Lodges,—

(a) Where it is the part of the constitution that the doctor shall attend the families, the minimum fee to be 30s. Where it is optional, the minimum fee to be 40s. Children to cease to be eligible for attendance at the age of fifteen.

(b) As alternatives, to lower the age for children ceasing to be attended to ten years, when they are to become members of a juvenile lodge, and to reduce the tariff proportionally. Or to charge reduced fees (say 3s. 6d. for visit, and 2s. 6d. for advice at house), to be paid by the lodge or in advance by the patients themselves under penalty of being charged full fees. A fee to be charged for all certificates outside lodge certificates.

No member to make a reduction to lodge patients for midwifery fees. The mother and child not to be considered as lodge patients for three weeks after confinement.

THE HOMŒOPATHIC DIRECTORY.

We have been shown a small book, entitled "The British, Continental, and Colonial Homœopathic Directory" for 1887-88, issued by the Homœopathic Publishing Company, London. The portion relating to Australia is the only one in which we feel any interest, but as to that, we are bound to point out that the names of practitioners who possess qualifications and of others who are notorious as veritable quacks are mixed up in the most ludicrously impartial manner. Under New South Wales, the names of thirteen persons are given as Homœopathic practitioners, but of these, only two possess qualifications which entitle them to be placed on the Medical Register of that, in these matters, very easy-going colony. Of the other men mentioned several appeared before the recent Select Committee of the Legislative Council and calmly acknowledged that they had never received any medical training at all. We recommend a perusal of the report of this Select Committee to the compiler of this work, and think that if he is not ashamed of his list, the properly qualified men whom he has placed in such very questionable company assuredly will be. The book is truly Homœopathic in the minuteness of the doses of useful and correct information which it professes to administer.

THE MEDICAL SOCIETY OF JAPAN.

IN the report of the proceedings of a special meeting of the Sei I Kwai or Medical Society of Japan, held at Tokyo on November 30, 1887, the first business which occurred was the introduction by the President, Takaki-Kanehiro, F.R.C.S., Eng., of Miss Light, M.D., a recently-elected member of the society practising in Tokyo. This election shows a liberal and enlightened spirit we cannot too highly eulogise. Many of our readers may not be aware of the prominent position which is taken by modern European medicine in Japan, we therefore think it not out of place to say that the leading practitioners, who are really numerous, possess diplomas of the highest character, which they obtained after study in Europe, and the papers read at and the reports of the meetings of this society show how highly cultivated these gentlemen are, and how enthusiastically and thoroughly, medicine, surgery, and sanitation are practised in Japan, which but thirty years since was a sealed country against all European knowledge. The action of the State in these matters is far in advance of that of the Australian Governments, and the reports of the medical department of the Japanese Imperial Navy are almost a lesson to the world.

CHARGE OF MANSLAUGHTER
AGAINST A CHINESE DOCTOR.

A CASE of considerable interest, but of a very peculiar character, was recently tried at Ararat, Victoria, before Mr. Justice A'Beckett. It seems, a Chinese doctor, named Ah Wah, was called in by the friends of a young man named Frederick Lewin, to treat him for diphtheria, which he had in an aggravated form. After four or five days' treatment by the Celestial practitioner the victim was taken to the local hospital in a moribund condition, and found, on examination, to be suffering not only from diphtheria, as stated, but also from pneumonia, which had remained undiscovered. It was shown in evidence that the treatment adopted by the Chinaman consisted in the administration of a number of drugs impotent in such a case. The judge pointed out that though, undoubtedly, he had contributed to the death by his ignorant omission to employ fitting treatment, yet he had not actively injured the man by any overt act, and in his summing-up apparently suggested that Ah Wah, though ignorant, had done his best, and had acted at the request of the deceased's friends, who, by their action, had brought their trouble on themselves. The jury acquitted the prisoner.

THE MARYBOROUGH (Q.) MEDICAL
SOCIETY.

A MEDICAL SOCIETY has been formed at Maryborough, Queensland, of which Dr. Harricks has been elected the first President, whilst Dr. Garde is Honorary Secretary. We congratulate the members of the profession in that town and its neighbourhood on their enterprise in commencing this society. It cannot fail to be of service, not only to its members but to the public generally, for the discussion of the subjects that will come before it must lead to enquiry, and in the case of disease consequent on local sanitary neglect to attention and reform. We hope that the example of Newcastle (N.S.W.), Ballarat (Vic.), and of Maryborough (Qu.) will be followed by other provincial towns being convenient centres of districts with a sufficient number of resident medical men to form a society.

LETTERS TO THE EDITOR.

THE ACTION OF STROPHANTHUS IN EXTREME
CARDIAC FAILURE.

(To the Editor of the A. M. Gazette.)

SIR,—The following case, illustrating the action of strophanthus in extreme cardiac failure, may be of interest:—

Geo. B., æt. 13 years, suffering from mitral disease, due to acute rheumatism of a former date, was admitted into the Brisbane Hospital on February 23rd. On admission he was suffering from acute dyspnoea, amounting to orthopnoea, constant cough, hæmoptysis, and vomiting, even after fluids; his face was pale, lips blue, and the surface of his body covered with clammy perspiration; respiration, 66; pulse, 138, weak and small. A loud mitral murmur was heard, but its exact rhythm could not be made out, owing to the tumultuous and irregular action of the heart. On the supposition that the severity of his symptoms was in part due to the exertion he had undergone on his way to the hospital, he was ordered rest and stimulants only. On the following day, however, his condition was considerably worse, he had passed but four ounces of highly coloured urine, and had slept in snatches of a few minutes only, being quite unable to lie down; pulse 160, difficult to count from its irregularity; respirations about 80. At 9 a.m. he was given a hypodermic injection of four minims of tincture of strophanthus (Hewlett's). At 10.30, pulse 136, weak and small, but regular; respiration about 80 still. At noon 3 minims of the tincture were similarly given, and at 5 p.m. 2 minims more. At midnight the last dose was repeated. His breathing was now much easier, and he was able to take fluid nourishment; during the day he passed 6 ounces of urine.

February 25th.—Feels much better, slept three hours during the day, had one 2 minim injection during the forenoon; pulse 80, strong and full; respiration 52; hæmoptysis quite ceased; the mitral bruit can be clearly heard to consist of an obstructive and regurgitant murmur; passed 5 ounces of urine during the day.

February 26.—Slept most of last night; pulse 74;

respiration 88; passed 20 ounces of urine, which is much clearer, and contains less albumen.

February 27.—Pulse varying between 90 and 100; 10.30 a.m., a two minim injection given, the first for 48 hours, passed 25 ounces of urine.

February 28.—Slept comfortably during the whole of last night, in the recumbent position; passed 20 ounces urine. This morning his pulse was 77, but at 2 p.m. it had risen to 116. He was accordingly ordered two minims of the tincture every four hours by the mouth. During the day he passed 30 ounces of urine, nearly free from albumen.

February 29.—Quite comfortable, and free from dyspnoea.

March 1.—Pulse about 112; dose of strophanthus increased to three minims.

March 6.—Still taking three minims every four hours; pulse varies between 88 in the morning and 100 in the evening, when he has a temperature of about 99.8° or 100°. He is free from dyspnoea, except on exertion, and can lie in any position; is taking a nourishing diet, including fish for dinner, without feeling any dyspeptic symptoms, and his cough has almost completely disappeared.

As to the effect of the remedy in the foregoing case there can be little doubt. The patient, from an almost moribund condition, was brought to one of absolute comfort in 48 hours. I had previously frequently given strophanthus by the mouth with varying and not altogether satisfactory results, generally returning to digitalis. In this case it was injected, as the condition of the stomach caused everything to be immediately rejected.

If it were not rash to draw general conclusions from an isolated instance, it would seem that the drug given hypodermically is about nine times more powerful than when given in the ordinary way. With regard to the rapidity of its action when given in the former manner there can be no question, and, therefore, this mode of administration would appear to be especially indicated in what may be called a "cardiac emergency," such as the one above related. I am, Sir, yours faithfully,

F. E. HARE, M.B.

Brisbane Hospital.

MEDICAL ETIQUETTE.

(To the Editor of the A. M. Gazette.)

SIR,—If you would kindly express an opinion on the following, it would greatly assist in determining the future relations of two medical practitioners.

Two medical men practising in a country town are on unfriendly terms. A consultation is required, and A. writes to B. to arrange, but B. returns the letter unopened.

B. finding out the purport of the letter calls on patient (without having been asked) and makes an examination, leaving word with patient's friends that A. can call at his (B's) residence and hear his opinion. B. also calls on the two following days but is not again allowed to see patient.

Was it proper for B. to call and examine patient without A's knowledge?

What future relations should A. observe towards B.?

Yours faithfully, MEDICAL ETIQUETTE.

[We are of opinion that B. should not have visited the patient as alleged, but that he should have decided either to have met A. in the usual consultation, or have in no way interfered in the case. The future relation of the practitioners is a private matter on which we cannot advise.—ED. A.M.G.]

A CORRECTION.

(To the Editor of the A. M. Gazette.)

DEAR SIR,—Will you kindly contradict, in your next issue of the A. M. Gazette, the statement, or rather the inference to be drawn from the statement, concerning me in the March number, viz., that I had left Australia and was settled in practice in New Zealand? I was in New Zealand on a special engagement, and, that having terminated, I have resumed practice at Waverley.

Yours truly,

ROBERT H. TODD, M.D., F.R.C.S.I.

Cowper Street, Waverley,
April 5, 1888.

THE MONTH.

NEW SOUTH WALES.

THE Government have appointed Dr. MacLaurin (President of the Board of Health), Dr. Wilkinson, M.L.A., and a Mr. Quinn, to represent New South Wales, on the Intercolonial Rabbit Commission. The Victorian representatives are Professor Allen, Dean of the Faculty of Medicine at Melbourne University; Mr. E. H. Lascelles, of Geelong, and Mr. A. N. Pearson. The South Australian delegates are Dr. Stirling and Dr. Paterson. Queensland will be represented by Dr. Bancroft; and New Zealand by Mr. Arthur Bell, son of Sir F. Dillen Bell. The commission will, it is understood, commence its labors on Monday, April 16.

M. LOIR, the nephew of M. Pasteur, who comes to Australia for the purpose of claiming the reward offered by the New South Wales Government for the best means of eradicating the rabbit pest, arrived in Australia early this month, by the R.M.S. "Cuzco." M. Loir, who is comparatively a young man, is accompanied by Dr. Germont, a French physician, and Dr. Hinds, an English physician, and they will in conjunction make the necessary experiments in Sydney which are intended to demonstrate the efficacy of M. Pasteur's method.

In the Legislative Council, on March 22, Sir Alfred Stephen moved a motion which contemplated that an inexpensive hospital should be erected in the neighbourhood of Macquarie-street, Sydney, and the present unfinished building should be appropriated to public offices. Dr. Renwick moved an amendment which affirmed "That provision is urgently required for the proper accommodation both of medical and surgical cases, instead of the highly dangerous wooden structure at present employed for that purpose, and this House is of opinion that the subject is one deserving the immediate attention of the Government." After a considerable amount of discussion, the original motion was agreed to on division of 20 to 6 votes.

At the Mudgee Circuit Court on April 5, the case of Bennett v. Floyer, both medical men practising at Gulgong, was called. The action was for libel, the damages being laid at £2,000. The case had proceeded half-way, when a settlement was arrived at by the defendant (Dr. B. B. Floyer) expressing regret and apologising to Dr. Reginald Bennett, for having made the statement constituting the alleged libel. The suit was then withdrawn.

A CASE of confluent small-pox was discovered at

Manly, near Sydney, on March 31; the patient, a child two years old, died on April 6.

THE "Dairies Supervision Act" has been extended to the Borough of Narrandera.

DR. H. N. MACLAURIN, Medical Adviser to the Government and Vice-Chancellor of the University of Sydney, has had conferred on him by the University of St. Andrews, Scotland, the degree of LL.D., *honoris causa*.

WE are pleased to learn that Dr. John Kerr, Resident Surgeon at the Newcastle Hospital, has recovered from the attack of diphtheria which lately confined him to bed.

DR. F. P. BARTLETT has returned to the colony from his trip to England, and resumed practice at Cowra.

DR. W. R. CLAY, of Rockdale, has been appointed Acting Health Officer for the City of Sydney, owing to the indisposition of Dr. Dansey, City Health Officer.

DR. F. G. DALTON, late of Picton, has removed to Robertson, 14 miles from Moss Vale.

DR. CRAIG DIXSON, of Sydney, has resigned his position as Chairman of the City Improvement Board; the Board accorded a vote of thanks to Dr. Dixson for his services.

DR. F. G. FAILES has removed from Cassilis to Coonabarabran, where he has been appointed Medical Officer of the local Hospital.

DR. B. McDONOUGH has settled at Hill End, where he has been appointed Medical Officer of the local Hospital.

THE Hon. Dr. C. K. Mackellar, M.L.C., of Sydney, returned to the colony by the R.M.S. "Rosetta," after an absence of twelve months in the old country.

DR. E. S. PIERCEY, late of Wagga, has commenced practice at 132 Glenmore-road, Paddington, Sydney.

DR. B. SCHWARZBACH, of Sydney, prior to his departure for Europe by the "Zealandia," was presented, on behalf of about 50 ladies, with a beautiful gold watch and chain, accompanied by the following address, which was very prettily engrossed:—"Dear Dr. Schwarzbach,—On behalf of the ladies, whose names are given below, we have great pleasure in asking your acceptance of the accompanying gift, with the hope that it may help to remind you of the many friends here who unite in wishing you a prosperous voyage, a pleasant meeting with your relatives and friends, and a speedy return to Sydney.—(Signed) EMMA AIREY, Hon. Secretary; M. F. GILFILLAN, Hon. Treasurer."

DR. ANDREW SEMPLE, of Brushgrove, has removed to Quirindi, 217 miles N. of Sydney.

DR. G. WATT, of Kempsey, has removed to Cobar, where he has been appointed Surgeon to the Great Cobar Copper Mine.

NEW ZEALAND.

DR. E. W. ALEXANDER, of Dunedin, in a pamphlet on "Insanity in New Zealand," just published, states that the proportion of the insane to the population of New Zealand (1 in 320) is much about that of other civilised countries. Of 1,613 inmates of New Zealand asylums 1,302 came from the United Kingdom, and about 150 from the Continent and America, and 111 only were New Zealand born. The Maoris contribute 21 for a population of 50,000, illustrating the far less frequency of brain disturbance in a savage race. The annual increase of insane in the asylums is about 80. Dr. Alexander condemns the policy of having large

asylums with 400 or 500 inmates, and prefers small asylums and the boarding-out of harmless cases with families, as is the plan adopted in Scotland.

At the suggestion of Dr. Leger Erson, of Otahuhu, the Board of Management of the Auckland Hospital propose to establish a dental department in connection with the institution, in order to enable Auckland students to qualify themselves for the New Zealand dental diploma.

At the Auckland Supreme Court on March 28, Archibald Douglas, of Waipu, an old man of venerable appearance, was arraigned on a charge of supplying medicine to a servant girl, with intent to procure abortion; he was found guilty, and sentenced to six months' imprisonment without hard labour.

DR. T. J. RENNIE (M.D., Mich. Coll. of Med., U.S.A.), who is connected with a Canadian lady Doctor, was committed for trial on March 21st, at Dunedin, for alleged indecent assault on a girl of 17 years of age, who was consulting him. It was contended for the defence that the charge was a trumped up one. Bail was allowed, and Dr. Rennie was released.

DR. T. W. BELL, M.D. Edin., of Auckland, has been admitted to the *ad eundem* degree of M.D. of the New Zealand University.

DR. L. M. CORDNER has settled at Rakaia, 36 miles S.W. of Christchurch.

DR. A. C. DE RENZI has settled at Christchurch, where he has been appointed House Surgeon of the local hospital, on probation for three months.

DR. W. T. HANNAH has settled at Ashburton, in a fine agricultural and pastoral district, 55 miles S. of Christchurch.

DR. JAS. IRVING, of Christchurch, Honorary Surgeon to the Mounted Rifles, was thrown from his horse at parade at Hagley Park on March 22, and broke his left leg.

DR. JAS. MACPHERSON, late of Invercargill, has removed to Caversham, a suburb of Dunedin.

DRS. SPRATT AND BEY, of Greytown (Prov. Wellington), have been appointed members of the Licensing Committee for the Greytown Borough.

QUEENSLAND.

WE are pleased to learn that a Medical Society has just been established at Maryborough; Dr. J. H. Harricks has been elected its first President, and Dr. H. C. Garde, Honorary Secretary.

DR. W. A. BROWNE, of Bowen, has been elected Chairman of the Chamber of Commerce, which has just been formed there.

DR. J. CHRISTIAN has settled at Allora, in a rich farming district, 156 miles S.W. of Brisbane.

DR. G. O. WILLIS has been appointed Surgeon of the Barcardine Hospital, at a remuneration of £150 a year.

SOUTH AUSTRALIA.

THE Government has appointed Drs. Stirling and Paterson to represent the colony at the conference in Sydney to investigate the scheme for the destruction of rabbits.

AN action brought by Dr. Alexander Lawrence, of Adelaide, in the Supreme Court, against Dr. Hartley Dixon, now of Mannahill, was concluded on March 28. Dr. Lawrence claimed £1,000 damages from Dr. Dixon, for breach of agreement in connection with the

sale of his medical practice in Adelaide to the plaintiff under certain conditions, one of which was that the defendant should introduce the purchaser of the practice to his patients. His Honor Mr. Justice Bunday gave judgment for the plaintiff—damages £400—with costs, holding that the defendant had not used diligence in the discharge of his obligations, and had not carried out certain other terms in the contract.

PROFESSOR WATSON, of the Adelaide University, who had been absent from South Australia for about three months, returned by the "Carthage" last month. About Christmas time he voyaged to Egypt, and spent the greater portion of his holiday up the Nile, proceeding as far as the second cataract. Leaving Egypt he spent a short time at Constantinople, and caught the homeward steamer at Brindisi.

THE examination of members of the Port Augusta Branch of the St. John's Ambulance Association was held on March 7 by Dr. Purves, nine candidates attending. There was a final meeting of the Branch previously, at which a resolution was passed to present an address on parchment to Dr. Astles in recognition of his services as Honorary Lecturer to the Branch.

DR. S. J. MAGAREY, of Adelaide, has successfully passed the examination for the degree of M.D. of the University of Melbourne.

DR. MARTEN has succeeded to the practice of Dr. O. Görgen, of Adelaide.

DR. A. RICHARDSON, late of Glenelg, has removed to Ororoo, 176 miles N. of Adelaide.

DRS. E. C. STIRLING AND J. DAVIES THOMAS, of Adelaide, have been elected members of the Council of the University of Adelaide.

VICTORIA.

THE Royal Society of Victoria passed a resolution at its annual meeting on March 8, protesting against the introduction of any disease for the extermination of rabbits until such disease has been thoroughly tested.

THE Government have issued a proclamation appointing the members of the proposed Health Commission, and defining the scope of their duties. The gentlemen selected to act are Professor H. B. Allen, Professor D. O. Masson, Mr. R. Reid, M.L.A., Mr. T. M. Girdlestone, Mr. A. P. Akehurst, Mr. J. Campbell, Mr. C. Hodgkinson, and Dr. W. M'Crea. Dr. G. A. Syme has been appointed by the Commission as Secretary. The members of the Commission are instructed to inquire into and report upon the sanitary condition of Melbourne and its suburbs, to ascertain to what extent the existence of noxious trades and abattoirs injuriously affects the public health, whether it is necessary or desirable to remove these trades and abattoirs from their present sites, and, if so, to suggest other sites. In addition, the Commission are to consider the various municipal systems of dealing with refuse matter; and to suggest such changes and improvements as may be deemed necessary, and such as may require legislation.

THE Central Board of Health recently received a telegram from Korait, in the Western District, stating that typhoid fever had broken out there, and that the Belfast Hospital authorities had refused to receive the patients. The President pointed out that under the 89th section of the Health Act the Board had power to make an order compelling any Hospital which received aid from the Government to receive such patients, and consequently it was resolved to make an order for the admission of the patients on the Belfast Hospital and

on the Warrnambool Hospital, where there was a special fever ward.

THE Central Board of Health, to show their recognition of the activity displayed by Dr. T. Elmes, Public Vaccinator of Berwick, in the performance of his official duties, have voted him a gratuity of twenty guineas.

FROM the 19th to 28th of March 140 cases of typhoid fever were reported to the Central Board of Health, 33 of which were fatal. This makes a total of 936 cases since the 1st December, 198 having proved fatal. During the same period there were 100 cases of diphtheria, 48 having been fatal.

AN outbreak of what was supposed to be smallpox was, on March 26, reported from Gordon, in the Ballarat District; the house in which the patient resided was at once isolated, but Dr. Shields, who arrived from Melbourne by special train, pronounced the case to be one of chicken-pox, and the isolation of the family was discontinued.

THE proprietress of a baby farm in Fitzroy, near Melbourne, was, on March 26, at the local Police Court, fined £5, with the option of one month's imprisonment, for retaining for hire more than one infant under the age of two years for the purpose of nursing apart from their parents, for a longer period than 24 hours, her house not being registered for the purpose, as required by the Health Act.

A DEATH from the administration of chloroform occurred at the Kyneton Hospital on March 30.

DR. W. BALLS-HEADLEY has returned to Melbourne from his trip to England, and resumed practice in temporary rooms, at 93 Collins Street East.

DR. J. F. COBB, late of Warragul, has removed to Fitzroy, a suburban city of Melbourne.

DR. JOHN FULTON, of Melbourne, has been appointed a Director of the Royal Humane Society of Australasia.

DR. L. HENRY, M.D. Würzburg, has been admitted as a M.D. (a.e.g.), of the Melbourne University by the Council, contrary to the recommendation of the Professional Board.

DR. A. J. JOSKE, late Resident Medical Officer of the Alfred Hospital, Melbourne, has commenced practice at Greville Street, Prahran.

DR. LAWTON, of Lancefield, while proceeding to the scene of an accident at the Lancefield Races, on March 14, collided with a horseman returning from the races, and was violently thrown to the ground, sustaining a serious shock to the system.

DR. F. R. LONGDEN has settled at Buninyong, 98 miles W. of Melbourne.

DR. RIVIS MEAD, late Surgeon to the Seaside Home, Whitby, Yorkshire, has settled at Kaniva, 313 miles N.W. of Melbourne.

DR. W. J. R. NICKSON, late Clinical Assistant at the Meath Hospital, Ireland, has commenced practice at Geelong.

DR. J. W. SPRINGTHORPE has resigned his position as Hon. Pathologist to the Alfred Hospital, near Melbourne.

DR. W. WARREN, of Kew, is about to visit the old country; during his absence in Europe his practice will be carried on by Dr. J. Wallace Watson.

DR. W. ATKINSON WOOD, late Resident Medical Officer of the Melbourne Hospital, and of the Prince Alfred Hospital, Sydney, has commenced practice at "Corowa," Wattletree-road, Malvern, near Melbourne.

MR. L. A. CARTER, of Melbourne, has been appointed Hon. Dentist to the Alfred Hospital.

WESTERN AUSTRALIA.

DR. J. T. LAFFAN, of Wyndham, Cambridge Gulf, has been appointed to act temporarily as Government Resident, Magistrate of the Local Court, Chairman of the Court of General Sessions, and Sub-Collector of Customs and Internal Revenue of the East Kimberley District, *vice* C. D. Price, Esquire, who has been granted leave of absence.

DR. F. A. INGOLDBY has removed from Fremantle to Albany.

HOSPITAL INTELLIGENCE.

AT a meeting of the Committee of Management of the Alfred Hospital, Melbourne, Dr. W. H. Embling, Chairman of the Hon. Medical Staff, reported that at a meeting of the staff, held on March 5, is was resolved "That it is inadvisable for any individual member of the staff to be named in the public press in connection with cases reported from this Hospital." Dr. Embling also suggested that the opening of the Clinical School in connection with the Alfred Hospital should take place on Monday, March 19, at 4 p.m. This was agreed to, but the school being on a very small scale at present, it was resolved that beyond the inaugural lecture by Dr. Embling there should be no public display. A report on the Nurse-training School stated, that, since the opening of the school in December, 1880, 76 nurses had been trained, of whom 9 remain in the Hospital; 128 families had obtained nurses in private cases. In April, 1886, classes were opened for lady visitors, of whom 45 attended; 28 applicants for training are now waiting for vacancies.

THE new school for clinical instruction at the Alfred Hospital, Melbourne, was opened on March 19 by the chairman of the Hon. Medical Staff, Dr. W. H. Embling. There were seven University students in attendance, viz., six ladies and one male student. After a short address by the chairman, who welcomed the students to the institution and encouraged them to persevere in their work, the students commenced their course under the respective surgeons in the out-patients' ward.

DR. WATSON MUNRO, Secretary of the hon. medical staff of the Sydney Hospital, has informed the board that at a meeting of the hon. medical staff, held on the 10th March, Dr. Harman Tarrant had been elected to represent the surgeons at the board, and Dr. W. C. Wilkinson to represent the physicians.

AT a meeting of the board of management of the Sydney Hospital, held on April 3, the following notice of motion was given by Mr. A. C. Shadler:—"That the attendances of the hon. medical and surgical staff during each month shall be read at every monthly meeting of the board. The attendance record shall be taken from the respective signature-books provided for that purpose, and that these monthly records shall be compiled and published in the annual report."

DRS. F. H. MEYER, M. U. O'SULLIVAN, W. D. HOOPER, AND ROTHWELL ADAM were, on March 23, elected Hon. Physicians of the Melbourne Women's Hospital; there were 12 candidates for the appointments.

THE Committee of the proposed Cottage Hospital at Bowral (N. S. Wales) have purchased a site of 5½ acres for £360. They propose to start building at once. The funds in hand at present are £800, and it is expected that the Government will afford the assistance of a special grant in the purchase of the site.

UNIVERSITY INTELLIGENCE.

AT a meeting of the Senate of the University of Sydney, held on March, 23, Professor Stuart gave notice of the following motion:—"That a Committee be appointed, to confer with a Committee of like number already appointed by the Board of the Prince Alfred Hospital, in reference to the appointment of certain University Medical Officers. That the Committee consist of the Chancellor, the Vice-Chancellor, Bishop Barry, the Hon. Dr. Renwick, and the mover.

AT a recent meeting of the Senate of the Sydney University, a letter was received from the hon. Secretary of the Prince Alfred Hospital, covering a resolution which had been passed by the Medical Board of the Hospital, in reference to the teaching of Ophthalmic Medicine and Surgery, recommending that the University should appoint a lecturer in that subject. Professor Stuart then gave notice of the following motion:—"That the Senate, having considered the recommendation of the Medical Board of the Prince Alfred Hospital, that the Senate should appoint a lecturer in Ophthalmic Medicine and Surgery, is willing to make such an appointment if the Board of Directors will place a sufficient number of beds under the charge of the officer appointed, in order to afford him the means of giving proper illustrations of his lectures."

THE Senate of the New Zealand University has resolved that the Senate apply to all institutions of the United Kingdom which grant degrees or diplomas in medicine or surgery, praying them to grant students of the University the same status and same privileges as are now granted by the University of Edinburgh.

OBITUARY.

HENRY READ.

DR. HENRY READ, M.D. Cooper Med. Coll., San Francisco, L. et L. Mid. R.C.P. Edin., L. et L. Mid. F.P.S. Glasg., 1883, died very suddenly of heart disease at Wickham-terrace, Brisbane, on March 24. Dr. Read was the youngest son of the late Rev. W. Read, rector of Worthing, Sussex. His educational course commenced at the Manchester Grammar School, and he then entered St. John's College, Cambridge. On the completion of his University career, Mr. Read was ordained, and he was then appointed inspector of schools in British Guiana under the late Duke of Newcastle, and of St. Kitts under the Right Hon. Ed. Cardwell. He was also chaplain to the British forces in the West Indies and British Honduras. Afterwards he became first Hughes professor of classics and philology at the Adelaide University, where he was twice elected dean. Mr. Read then resigned holy orders and completed his medical curriculum, taking the degrees above referred to. Although the deceased gentleman arrived in Brisbane from Melbourne only a short time since, he had already made numerous personal friends.

Medical Books at PUBLISHED Prices.

MR. BRUCK, Medical Bookseller in Sydney, begs to inform the profession that he is selling all medical books at PUBLISHED prices. A list of some of the books in stock, with published prices attached, will be found in this issue. Mr. Bruck has also a few copies of the *Lancet* from January 1, 1888 (English date), to spare, at 45s. a year, postage paid to any of the colonies.

VITAL STATISTICS OF AUSTRALASIAN CAPITALS, 1887.

Return showing the population, the births and deaths, and their proportions to population, and the excess of births over deaths in each of the following metropolitan cities of Australasia in 1887:—

Capital Cities. *	Estimated Population	Births.		Deaths.		Excess of Births over Deaths.	
		Total Number.	Number per 1,000 of the Population.	Total Number.	Number per 1,000 of the Population.	Numerical	Centesimal
Melbourne ...	391,546	14,583	37·24	8,324	21·26	6,259	75·19
Sydney ...	348,695	13,415	39·37	5,558	16·31	7,857	141·36
Brisbane ...	55,475	2,419	43·61	1,049	18·91	1,370	130·60
Adelaide ...	112,312	3,859	34·36	1,849	16·46	2,010	108·71
Hobart ...	31,251	1,057	33·82	804	25·73	253	31·47

* With suburbs.

It will be noticed that the birth-rate was higher in Melbourne than in Hobart or Adelaide, but lower than in Brisbane or Sydney; also that the death-rate was higher in Melbourne than in any of those cities except Hobart. The excess of births over deaths was lowest in Hobart, and next in Melbourne. In the other three capital cities named the births were more than twice as numerous as the deaths.

VITAL STATISTICS OF MELBOURNE AND SUBURBS FOR 1887.

THE estimated population of Melbourne and suburbs (Greater Melbourne) about the end of the third quarter of 1887 was 391,546, the increase upon the estimate made twelve months previously being 19,916.

The births in Greater Melbourne during 1887 numbered 14,583, or 37·24 to every 1,000 of the population. The birth-rate was the highest in the last 17 years. The number of children set down as born out of wedlock during 1887 was 1,031, or 121 more than in 1886. The proportion of illegitimate births to the whole number of births registered was 1 to every 14 in both years. Of the total births registered, 51 per cent. were males, and 49 per cent. females.

The total number of deaths reported in Greater Melbourne during 1887 numbered 8,324, or 21·26 per 1,000 of the population; of these, 4,562, or 55 per cent., were males, and 3,762, or 45 per cent., females; 3,459, or 42 per cent. of total deaths, were under 5 years of age, viz., 1,874 boys, and 1,585 girls. The deaths of 412 persons, viz., 232 males, and 180 females, of the age of 75 years and upwards, occurred during 1887. 1,386 deaths, or 17 per cent. of the whole, took place in public institutions, viz., 584 in the Melbourne Hospital, 187 in the Alfred Hospital, 41 in the Homœopathic Hospital, 37 in the Children's Hospital, 51 in the Women's Hospital, 115 in the Immigrants' Home, 116 in the Benevolent Asylum, 59 in the Yarra Bend Lunatic Asylum, 94 in the Metropolitan Lunatic Asylum, 40 in the Austin Hospital, 29 in the Melbourne Gaol, etc.

Of the 8,324 deaths recorded during the year, 993 were due to diseases of the brain and nerves, 910 to phthisis, 896 to diseases of digestive organs, 563 to dysentery and diarrhoea, 528 to heart diseases, 527 to pneumonia, pleurisy, and disease of lungs undefined, 344 to bronchitis and laryngitis, 338 to typhoid fever, 248 to cancer, 137 to croup and diphtheria, 96 to child-bearing (or 1 death of a mother to every 158 infants born alive), 64 to measles, 43 to whooping cough, and 3 to scarlet fever.

VITAL STATISTICS OF SYDNEY AND SUBURBS FOR 1887.

THE estimated population of the city and suburbs of Sydney at the close of 1887 was 348,695. Of these 181,140 were males and 167,555 females, showing a difference in favor of the males of 13,585. The number at the close of the previous year was 332,709; the increase during 1887 was, therefore, 14,986, or at the rate of 4·8 per cent.

The number of births registered in Sydney and suburbs during the year 1887 was 13,415, viz., 6,694 males and 6,721 females; the birth-rate per 1,000 of the estimated population was 39·37, or nearly the same as the average rate for the previous 10 years, viz., 39·66. Out of the total of 13,415 births for the year, 873, or 6·51 per cent., were illegitimate.

The deaths registered in Sydney and suburbs during the year 1887 numbered 5,558, or 16·31 per 1,000 of the population, of which 3,072 were males and 2,486 females, the excess of the former over the latter being 586. Adding this to 27, the number by which the female exceeded the male births, we find that there is a surplus on the year of 613 in favor of the females. The total deaths under 5 years of age amounted to 2,624, viz., 770 (or 39·65 per cent. of the total) in the city, and 1,854 (or 51·27 per cent., or more than half the total deaths) in the suburbs. The deaths of children under 5 years compared with the total living show 50·50 per 1,000 children in the city, and 57·86 per 1,000 in the suburbs. The deaths of children under the age of one year numbered 1,892, viz., 573 in the city and 1,319 in the suburbs.

The greatest number of deaths in the city (891, or 45·88 per cent. of the total) was from diseases of the local class. Of deaths from developmental diseases (5·51 per cent.) 61 were from premature birth, 22 were from malformations, and 24 from old age.

In the suburbs, also, local diseases claim the largest number of victims, 1,693, or 46·83 per cent. of the aggregate, having succumbed to diseases in this class. The proportion of deaths from specific febrile or zymotic diseases was 15·14 per cent. Comparison of the suburban death-rolls for 1886 and 1887 shows that

there were fewer deaths from each class of disease in the latter year than in the former. The greatest difference is to be found in the zymotic class, and although in 1887 the fatal cases of diphtheria, scarlet fever, typhoid fever, and diarrhoea were somewhat numerous, the deaths from each of these diseases, with the exception of the first-named, fell short of the numbers registered in 1886.

During 1887 the deaths from zymotic diseases amounted to 857. Of these diarrhoea claimed the largest number of victims—83 died in the city, of whom 75 were under and 8 above five years of age; while 245—of whom 230 were under and 15 above five years of age—died in the suburbs; the total deaths numbering 328. The deaths from typhoid were not as frequent during 1887 as in the previous year, the deaths numbering 198, or 101 less than in the previous year. Of the number dying from this cause, 46 were residents of the city and 152 of the suburbs. The loss of life occasioned by typhoid during the last 13 years has amounted to 2,077.

There were 66 deaths of child-bearing women during the year—viz., 28 in the city and 38 in the suburbs, or 1 death of a mother to every 208 births registered.

WE have been requested to publish the following particulars as regards

THE WILLIAM F. JENKS MEMORIAL PRIZE.

The First Triennial Prize of Two Hundred and Fifty Dollars, under the Deed of Trust of Mrs. William F. Jenks, will be awarded to the author of the best essay on

"THE DIAGNOSIS AND TREATMENT OF EXTRA-UTERINE PREGNANCY."

The conditions annexed by the founder of this prize are, that the "prize or award must always be for some subject connected with Obstetrics, or the Diseases of Women, or the Diseases of Children;" and that "the Trustees, under this deed for the time being, can in their discretion publish the successful essay, or any paper written upon any subject for which they may offer a reward, provided the income in their hands may in their judgment be sufficient for that purpose, and the essay or paper be considered by them worthy of publication. If published, the distribution of the said essay shall be entirely under the control of the said Trustees. In case they do not publish the said essay or paper, it shall be the property of the College of Physicians of Philadelphia."

The prize is open for competition to the whole world, but the essay must be the production of a single person.

The essay, which must be written in the English language, or, if in foreign language, accompanied by an English translation, should be sent to the College of Physicians of Philadelphia, Pennsylvania, U.S.A., addressed to Ellwood Wilson, M.D., Chairman of the William F. Jenks Prize Committee, before January 1, 1889.

Each essay must be distinguished by a motto, and accompanied by a sealed envelope bearing the same motto and containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay.

The Committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents within one year.

The Committee reserves the right to make no award if no essay submitted is considered worthy of the prize.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Haydon, James Augustus, M. & L. Mid. R.C.S. Eng., 1886; L.S.A. Lond., 1886.
Long, Sinclair Andrew, L.R.C.S. Irel., 1886; L.K.Q.C.P. Irel., 1886.
Huxtable, Louis Balston, M.B., M.S. Edin., 1881.
Drinkwater, Charles, M.R.C.S. Eng., 1886; L.R.C.P. Lond., 1887; L.S.A. Lond., 1886.
Rutledge, David Dunlop, M.B. Syd., 1888.

NEW ZEALAND.

Cordner, Louis M., L.R.C.S. Irel., L.K.Q.C.P. Irel., 1886.
Bolger, Patrick T., L.R.C.S. Irel., L.K.Q.C.P. Irel., 1886.
Hannah, William Tweed, M.B. & Ch. M. Edin., 1886.
De Rens, Arthur Castriot, M.R.C.S. Eng., & L.S.A. Lond., 1887.

QUEENSLAND.

Sutton, Alfred.

TASMANIA.

McEniry, James Joseph, L. & L. Mid. R.C.P. & R.C.S. Edin., 1887; L.F.P.S. Glasg., 1887.
Westbrook, Richard Talbot, M.R.C.S. Eng. & L.A.H. Dubl., 1887.

VICTORIA.

Marwood, Arthur William, L. & L. Mid. R.C.P. & R.C.S. Edin., 1887; L.F.P.S. Glasg., 1887.
Nickson, Wilfrid John Robert, M.B. & Ch.B. Dubl., 1886.
Badon, Samuel Bailey, M.D. & Ch.M. Aberd., 1862.
Mead, Rivia, M.B. & Ch.M. Edin., 1883; M.R.C.S. Eng., 1883.
Shirreff, William Henry, L.S.A. Lond., 1879; M.B. & Ch.M. Edin., 1880.
Eadie, John McIntyre, M.B. & Ch.M. Glasg., 1887.

MEDICAL APPOINTMENTS.

Addison, George, M.D., M.R.C.S.E., to be Health Officer for Mitcham, S.A.
Bancroft, Peter, M.B. & Ch.M., Syd., to be Third Resident Medical Officer at the Prince Alfred Hospital, Sydney.
Beattie, Robert Ettingsall, L.R.C.S.I., L.K.Q.C.P., Irel., to be Government Medical Officer and Vaccinator for the district of Camden, N.S.W.
Brannigan, Henry Cooke, M.D. & Ch.M. Royal Univ. Irel., L.R.C.P. & R.C.S. Edin., to be a Surgeon in the Marine Defence Force, Qu.
Cobb, John Frederick, M.R.C.S. Eng., to be Public Vaccinator at Collingwood, Vic., vice Dr. A. Steven, resigned.
Falles, Frederick George, M.R.C.S.E., to be Government Medical Officer and Vaccinator for the district of Coonabarabran, N.S.W.
Hassell, Gray, M.B. & Ch.M. Aterd., to be Medical Superintendent of the Lunatic Asylums at Wellington and Porirua, N.Z.
Longden, Frank Reginald, L.R.C.P. & R.C.S. Edin., to be Public Vaccinator and Health Officer for borough and shire of Buninyong, Vic., vice O. H. W. Hardy, M.B., resigned.
Macdonald, George Childs, L.R.C.P. Edin., F.R.C.S. Edin., M.R.C.S.E., has been appointed Chloroformist at St. Vincent's Hospital, Sydney.
MacLachlan, Donald Archibald, L.F.P.S. Glas., to be Health Officer for Stirling, S.A.
Nolan, Lyster Andrew, L.R.C.S. Irel., L.K.Q.C.P. Irel., to be Health Officer for shire of Warragul, Vic., vice J. F. Cobb, M.R.C.S., resigned.
Penny, John Alexander Cairns, L.R.C.S.I., L.K.Q.C.P. Irel., to be a Surgeon in the Queensland Marine Defence Force.
Read, George, L.R.C.S. Irel., to be Government Medical Officer and Public Vaccinator for the district of St. George, N.S.W.
Richardson, Arthur, M.D., M.R.C.S.E., L.R.C.P. Edin., to act as Medical Officer to attend to the destitute poor and aborigines within the districts of Orroroo, Coomooroo, Erakina, Morgan and Pekina, S.A.
Semple, Andrew, M.B. & Ch.M. Glas., to be Government Medical Officer and Public Vaccinator for the district of Quirindi, N.S.W.
Weid, James Charles, L.R.C.S. Irel., L.K.Q.C.P. Irel., to be Health Officer for Werracknabeal, Vic.

REPORTED MORTALITY FOR THE MONTH OF FEBRUARY, 1888.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Group and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Bronchitis.	Pneumonia.
N. S. WALES.														
Sydney	132,846	312	240	123	9	3	6	...	7	25	25	12	6	8
Suburbs	215,849	798	405	242	11	8	3	2	17	40	30	15	8	7
NEW ZEALAND.														
Auckland	35,965	90	43	24	...	...	...	1	1	6	...	1	...	...
Christchurch	16,217	37	17	8	...	...	1	...	1	3	1	2	...	1
Dunedin	24,384	60	21	4	...	...	1	...	1	1	...	1	...	...
Wellington	28,235	72	41	20	...	...	1	...	...	5	1	1	...	3
QUEENSLAND.														
Brisbane	51,689	162	88	45	} 1	1	4	2	5	13	12	5	4	2
Suburbs	21,960	131	33	14										
SOUTH AUSTRALIA.														
Adelaide	312,324	810	282	117	...	...	4	1	11	27	25	24	5	10
Adelaide	48,527	85	69	21	...	...	...	...	...	4	10	5	...	1
TASMANIA.														
Hobart	31,667	83	66	26	...	...	1	...	9	8	1	2	3	1
Launceston	19,849	70	46	16	...	...	1	...	2	1	1	5	1	3
Country Districts	91,141	...	...	...	...	...	...	...	...	...	...	...	...	...
VICTORIA.														
Melbourne	69,774	127	107	} 339	..	...	8	1	63	66	58	42	11	13
Suburbs	275,606	938	622											

METEOROLOGICAL OBSERVATIONS FOR FEBRUARY, 1888.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.			Depth.	Days.		
							Inches			
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E. ....	...	100.5	71.0	47.5	29.863	...	...	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.	153.7	78.0	65.3	54.5	...	...	1.340	12	69	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.	158.1	92.7	74.2	64.1	29.968	13.909	23	78	...	...
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.	153.8	89.0	61.3	41.4	...	1.961	11	62	...	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E. ....	...	...	...	...	...	...	...	...	...	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E. ....	...	88.8	61.7	41.3	29.881	20	7	71	...	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E. ....	...	89.0	66.1	39.3	29.940	0.7	2	63	...	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E. ....	...	97.2	64.9	43.1	29.907	0.42	6	...	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E. ....	...	87.8	70.8	59.8	30.006	3.17	17	71	N.W.	...
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.	143.7	73.3	60.9	46.5	...	1.693	11	72	...	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

SUCCESSFUL TREATMENT OF DIPHTHERIA.

By GEORGE REGINALD EAKINS, M.D. ET CH.D.
BRUX., L.R.C.P. ET L.R.C.S. EDIN., &C.,
ECHUCA, VICTORIA.

In this article I venture to give the results of a system of treatment which has, in my hands, I might say, amounted to a specific. Having had over sixty cases to treat within a period of three years, and with uniform success, I may safely hope that I shall be doing my professional brethren a good turn by pointing out a certain and rational mode of treatment; in the same period I have attended a good few cases that succumbed, but they did not come under my notice until too far advanced; and, if ever a child was brought to me suffering from this disease, and with decidedly croupous breathing, my prognosis was invariably that the disease would end fatally, because I then knew that the disease had made its way down the trachea too far, and the blood was too poisoned, and the system so far vitiated as to preclude recovery.

I have learned to look upon diphtheria as a form of *blood poisoning with local manifestations*, and on this theory the treatment I have pursued is based, and the results so far go to prove the correctness of the afore-mentioned theory.

TREATMENT.

The local treatment consists in washing the parts covered with the membranous exudation *once, and once only*, with a solution consisting of equal parts of liquor ferri perchloridi fortior and aqua, and care must be taken that every little spot is gone over carefully, no roughness or force being used, but quietly applied. I order the patients who are old enough to gargle the throat with the following:—℞ Acidi sulphurosi, one ounce to an ounce and a-half; glycerine from one and a half ounces to two ounces; aqua to eight ounces, every three hours, and to continue to do so until convalescence is complete.

Internally I administer a mixture containing liq. ferri perchloridi B.P., from v to xx minims, with syrup glycerine and water, not too diluted, every three hours until the disease is somewhat abated, then less frequently. *I give my iron mix-*

ture whether the stomach is irritable or not, and I find that most children will vomit anything styled "medicine," unless it is judiciously and firmly administered. I always clear out the bowels with calomel, if an aperient has not been previously administered, which is generally the case. I give in all cases this mixture without fear, and never alter it until the patient is better, the urgency of the symptoms must never make you falter or lead you to prescribe anything else.

No emetics whatever must be used, as I not alone consider it cruel, but positively culpable to administer such to an already exhausting child. Once the throat has been well touched with the afore-mentioned application, I never touch it afterwards, and the little patients learn to lose their dread of the medical attendant, when they find nothing further is to be done to the throat. I never allow hot poultices, sinapisms, or leeching.

The general treatment consists of a system of hyper alimentation, meat jellies, raw eggs, milk, and plenty of cold water. I never allow anything in the shape of a hard bolus to pass into the gullet, for fear it might disturb particles of the false membrane, and so be carried into the stomach, and further vitiate the blood. I also order at the same time brandy, or preferably good port, in iced or cold water; I like the stimulant well diluted. Whenever practicable I make my patients rinse the mouth and throat with plain cold water, tinctured with "Condy's Fluid" before swallowing any nourishment. In summer time I keep the sick room as cool as possible with plenty of fresh air; in winter time, or cold weather, I keep the room at a uniform comfortable temperature. I never allow steam or other sprays to moisten the atmosphere with, believing such to increase the accumulation of mucus, which is at times present in the bronchial tubes, sometimes on account of accompanying catarrh, more often the result of the inability or unwillingness of the little sufferer to cough, on account of the throat affection. If the bowels become confined, every second or third day one or two ounces of salad oil, with or without warm soap and water, may be injected according to age of patient, which secures sufficient evacuation.

In the above treatment—1. The astringent local application causes the false membrane to early shrivel up, and prevents its further spread.

2. The sulphurous acid gargle is soothing and antiseptic.

3. The single application is all that is necessary, and as little disturbance of the parts as possible is secured. The prohibition of poultices, sprays, and sinapisms, which are of more than

doubtful utility; also of a hot moist atmosphere, which worry and oppress the patient is avoided, and thus rest is secured.

4. The administration of alcohol prevents nitrogenous waste.

The objects sought to be obtained are—rest to the throat, freedom from irritating vapours which provoke cough, and to sustain and support the patient with a highly nutritious, easily digested regimen, and the administration of a drug which will prevent further changes in the blood.

A good deal has been said lately about the operation sometimes necessary, or had recourse to as a *dernier* resort, and notwithstanding the contrary opinion of so eminent an authority as Sir Morell Mackenzie, I think it highly essential, after the arms of the child have been pinioned by wrapping it up in a shawl, to administer a whiff or two of chloroform to *quieten* the patient, and not fully narcotise; care must be taken, as it takes *very little* to *anæsthetise* these patients. The operation being done according to Whitehead's method, which is bloodless, with this difference, that before making the incision into the trachea, I insert a sharp curved hook right into the trachea, and hold it forward until the incision is made and tube inserted, and then commence artificial respiration, or tickle the interior of the trachea with a feather until breathing through the artificial opening is fully established. I was led to stick the curved needle into the trachea as having proceeded to do the operation as described by "Whitehead," viz., by cutting the trachea between the finger and thumb, I accidentally wounded a vessel through the struggles of the child, and, before I could get the tube *in situ* my patient was literally drowned, and died on the table—a very undesirable accident; but this has not deterred me from again doing the operation, and I have now no ugly misgivings or difficulty in accomplishing the most difficult part of the operation, viz., the insertion of the tube.

The operation as above described can be performed in four minutes.

I intend in the next case I have to operate upon to cut out an elliptical piece with the scissors and suture back the tissues to prevent the encroaching on the opening into trachea, and put in *no tube whatever*, as the tube must act as a foreign body in the windpipe, and naturally we must expect distressing efforts to dislodge it from time to time. This deprives the patient of the rest and sleep which is an essential factor, in order to allow time for recovery from the diphtheria. The trachea and its opening can be very easily kept clear, I think, by passing a catheter or other mechanical means to free it from bronchitic or other secretions.

ON A FORM OF SORE THROAT SEEN IN ANÆMIC PERSONS.

READ BEFORE THE N. S. WALES BRANCH, B.M.A.

By R. SCOT SKIRVING, M.B., ASSISTANT HON. PHYSICIAN PRINCE ALFRED HOSPITAL, AND HON. PHYSICIAN TO THE SICK CHILDREN'S HOSPITAL, SYDNEY.

THE subject I wish briefly to bring before your notice this evening is that of a form of relaxed sore throat found in association with anæmia, and hence most often seen in young women. I do not doubt I am directing attention to what most of my colleagues have noted for themselves, but my excuse for bringing the matter up is that I have been unable, in the literature at my command, to find any definite notice of the condition, nor do I recollect in any of the Vienna clinics I attended special attention being directed to faucial trouble in connection with anæmia. During the past few years I have accumulated quite a budget of cases in which this association has existed, and these have occurred usually amongst the more comfortably off of my clientèle. For the most part these patients have not been examples of the extreme forms of anæmia, and I note that they occurred in other spare persons, and with only a few exceptions in cases where the anæmia was attended by the deposit of much subcutaneous fat. In none was there any renal, cardiac or pulmonary trouble. For the most part the loss of red cells and colouring matter seemed to be due to failure of digestion, to unwise dieting, or in connection with the evolution of sexual activity.

As to the throat itself, the subjective sensations were always greater than the objective alterations would seem to account for. The patients were hypersensitive and neurotic. In general terms this form of throat is of the relaxed variety. A common history would be that of a gradually increasing weakness in speaking, with some pain and stiffness in the throat, and lastly, actually considerable pain on deglutition, speech or singing. On examination, the mucous membrane as one would expect is pale, but with patches of rather deep congestion scattered here and there, for the most part behind the tonsils on either side. On several occasions I have noticed the same thing on the palatal mucous membrane. The mucous membrane though pale, is somewhat swollen and waxy looking, and in some cases I have noticed actually small submucoid hæmorrhages, and in many small dilated vessels are here and there to be seen. The follicles are large and flattened, and look like sago grains not fully boiled. The uvula is invariably long, and at its point is distinctly cedematous, no doubt due to

its dependent position, acting as it does, as a drip-stone for the posterior nares. There is on the whole a deficiency of moisture of the parts, and what mucoid secretion is hawked up is viscid and stringy. The cough, which is a prominent feature, comes in fits, as well as the short and dry bark. I may add that the larynx shows nothing abnormal beyond paleness and slight waxy swelling of the arytenoid mucous membrane. I have now seen so many similar cases that I am satisfied that the combination is not an accidental one, nor is it surprising that such a form of sore throat should exist as a result of anæmia; moreover, as I shall mention just now, remedies directed to the system-condition, cure the local trouble, topical treatment being a secondary consideration. After attending to such matters as the bowels, the diet, and the like, I give iron or iron and arsenic, and these drugs I push. For local treatment, after bathing the affected parts with a little alkaline fluid such as bicarbonate of soda and water, I order a rhatany or chlorate of potash lozenge. These small measures, combined with ferruginous tonics, I have, in almost every case, found efficacious. Occasionally I have been obliged to snip the uvula. The voice is however, apt to remain weak, and speaking easily tires the patient even some time after examination has shown the red discs and hæmoglobin to be up to the normal standard, and an absence of the humming-top sound that the cervical veins are sufficiently filled.

SUPRA-PUBIC LITHOTOMY.

By ERNEST HUMPHRY, M.R.C.S. ENG., L.R.C.P.
LOND., FORMERLY HOUSE SURGEON AND
MIDWIFERY ASSISTANT, ST. BARTHOLO-
MEW'S HOSPITAL, LONDON.

A. W., æt. 65, has suffered for the last three years from painful and frequent micturition, which was much aggravated by exercise; had to give up riding on account of the pain he suffered, and the quantity of blood he passed in his urine afterwards. He always felt the pain at the end of his penis. On December 16 I sounded him and at once came down on a stone that seemed to be of considerable size. He was anxious for its removal, saying that he would sooner be dead than suffering as he was.

On Jan. 4 Dr. McBurney administered chloroform, and Dr. Clarkson assisted me with the operation. A Barnes' india-rubber bag was put in the rectum and distended with air; a silver catheter was passed and tied in and about eight

ounces of water injected into the bladder. There was then dulness on percussion to about three inches above the pubes. An incision was now made about four inches long, in the middle line, extending to the pubes, the integument divided down to the bladder, which was easily made out by pressing upwards the silver catheter. The bladder was now seized by two pairs of artery forceps near the pubes and opened between, the injected water immediately rushed out, and the stone was easily felt; the catheter was now removed, and the incision in the bladder increased upwards and downwards, care being taken not to open the peritoneum, and the stone removed. The edges of the bladder were now sutured with catgut, but the mucous membrane was not included in the suture.

The skin and deep structures were sutured with silk, a drainage tube put in at the lower end of the wound and dressed with carbolized lint. A soft catheter was tied in the bladder.

10 p.m.—Very comfortable, pulse 72, temp. 99·2, blood-stained urine escaping freely by the catheter. Hypodermic injection of morphia gr. $\frac{1}{4}$ administered.

Jan. 5, 7 a.m.—Passed a good night, pulse 72, temp. 99·2, urine clear, some redness and œdema at the lower end of wound and along the dorsum of penis.

11 a.m.—Vomited, much pain in wound, pulse 84, temp. 101·2, redness on penis increasing. Three of the lowest sutures removed and the wound opened slightly, injection of morphia gr. $\frac{1}{4}$.

11 p.m.—General condition much improved, feels quite comfortable, pulse 78, temp. 99.

Jan. 6, 7 a.m.—Good night, pulse 78, temp. 99, wound looks healthy, redness on penis disappearing. Urine smells offensive, catheter changed and the bladder washed out with boracic acid \mathfrak{z} i. to one pint.

Jan. 7.—Suffered a good deal in the night with wind, feels as if his bowels wanted to be opened; an enema administered, but while straining some urine escaped through the wound.

Jan. 8.—Is fairly comfortable, still some urine escaping through the wound, the catheter is continually getting blocked by discharge.

Jan. 10.—Very uncomfortable from the escape of urine, suffers no pain, wound looks well at upper part.

Jan. 14.—Keeps very much the same, all the upper part of wound quite healed, very little urine coming through the catheter.

Jan. 18.—The catheter taken out, a thick pan of lint firmly strapped over the wound, allowed to get up, passed a little urine naturally, twice, but is still escaping freely through the wound.

Jan. 24.—Is passing his water naturally, done

escaped through the wound for three days, has been out of doors for a walk.

Jan. 31.—Wound quite healed, expresses himself better than he has been for years, no trouble with micturition, can hold his water comfortably for six hours, urine clear, no albumen.

Remarks:—The stone, which was before the operation felt to be a large one, weighed over five ounces, and was eight-and-a-quarter inches in the largest circumference, oval in shape and outside composed of phosphate of lime; I have been unable to have it cut yet. The supra-pubic operation seems to be the fashion now, but the size of the stone left me no choice in the matter. The redness and oedema at the lower end of the wound and on the penis was the only symptom that caused me alarm, as I thought a little extravasation of urine had taken place; however, that all disappeared on opening up the wound a little.

Mackay, Queensland.

CASE OF INCISED WOUND OF KNEE, ENTERING THE JOINT.

By EDWARD YEATES, L.R.C.S. IREL.,
L.K.Q.C.P. IREL., MEDICAL OFFICER,
WARIALDA HOSPITAL, N. S. WALES.

On the 9th of April, 1887, I was summoned to see a man, J.M., 30 miles away, who was suffering from an axe wound in the left knee, which he had received eight or nine days previous to my being summoned.

History of the case.—The patient was ring-barking and the axe slipped, the corner of the blade entered the knee at head of tibia and inner side of patella, apparently entering the joint slightly; the hæmorrhage at time of accident was profuse; a week after the accident, patient was driven to the place where I saw him (from where the accident occurred, a distance of 30 miles), and owing to the great jolting he received, the hæmorrhage again commenced and continued for several hours. When I saw the limb it presented the following appearance, viz.: a gaping wound about one inch in length, to inner side of patella, with a most fetid discharge running from it, joint suffused and hot, also greatly enlarged. Patient complained of intense pain in neighbourhood of wound when the limb was moved; he was very feverish. Having squeezed out much pus (sanious), which contained a synovial-looking fluid, I washed the wound with carbolic lotion, bandaged the limb, and applied to it a roughly made splint of bark, and ordered the patient to be brought into the hospital without delay. He was brought into the Warialda District Hospital on

11th April. On removing splint and dressings, I found them soaked with the fetid discharge and I squeezed out nearly an ounce of pus from a sac which occupied the upper and *external* border of patella, and from a smaller sac at inner border of patella. Having thoroughly washed out the wound by syringing with carbolic lotion (1 in 40) I dusted it well with iodoform, bandaged the leg from foot up and swung the limb in "Salter's Fracture Cradle." The following morning there was still a considerable discharge, so I applied a lint compress over sac external to patella, and bandaged firmly, dressing with iodoform, which I carried well into the wound, on a silver probe; dressed again in the evening, discharge lessened, no bad smell, but there was still a slight discharge of synovial fluid, along with the pus. Dressed twice a day, using iodoform as above described, for the next two weeks, after which period discharge had almost ceased, and wound was beginning to granulate and close in, although patient still complained of intense agony if joint was moved.

On the 5th of May, noticing that the joint was hot, and as the patient was complaining of "throbbing" in it, I determined to leech it the following day if there was not some improvement, and in the meantime ordered hot fomentations, the wound having all healed up with the exception of a small opening at lower angle, about the size of a split pea.

6th May.—I was called up by the wardman at 3 a.m. as alarming hæmorrhage had taken place (34 days from date of accident). The bed and swing were soaked with blood, which was dripping from bandages round the knee; on removing the bandages I found a bright arterial stream issuing from the small unhealed opening in wound, so I raised the limb and put a compress on the femoral artery, inserted a piece of lint soaked in tannic acid into wound, and thus stopped the hæmorrhage. Patient expressed himself greatly relieved by the hæmorrhage and while it continued allowed me to move the joint without much pain to him; from this period he continued to improve but still there was a slight discharge, which stopped finally about the end of May, when a piece of (apparently) diseased cartilage, about the size of a sixpence, came away.

When patient was discharged from Hospital on 11th July, the wound was completely healed up, but flexion of joint was very limited indeed.

The highest temperature attained was 101.5°. The medicines administered were simple tonics, and the diet was, of course, varied according to the state of the patient.

I saw the patient at his own residence on 24th July, he was then able to walk pretty well, but the knee was very stiff indeed, and although I explained

to him the reason of this, he (not possessing a particularly bright intellect) was very dissatisfied, and begged of me to cure the stiffness of his knee or, as he expressed it himself, "give him a bottle of 'stuff' to rub in the knee and make him able to bend it."

I again saw the patient on 20th December, when he appeared to be able to walk very well, and was also able to ride on horseback.

PROCEEDINGS OF SOCIETIES.

SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

MONTHLY MEETING held at the Adelaide Hospital, April 26, 1888. Present: The President (Dr. Davies Thomas), Prof. Watson, Drs. Cawley, Lendon, Mackintosh, Poulton, Verco, Messrs. Aitken, Anstey Giles, A. A. Hamilton, Hayward, Marten, Percy Wood, and the Hon. Sec. (Mr. Cleland).

The minutes of the meeting held March 29, 1888, were read and confirmed.

BALLOT.—Charles W. Purves, L.R.C.P. et S. Ed., and Geo. Woods, L.K.Q.C.P. Irel., were elected members of the British Medical Association, and of its South Australian Branch.

EXHIBITS.—Dr. Davies Thomas showed two patients who had been operated upon for hydatid of the lung. The cases are referred to at length in his paper on the diagnosis of pulmonary hydatids.

PATHOLOGICAL SPECIMENS.—Dr. Lendon exhibited a papillomatous tumour removed by thyrotomy from the larynx of a child aged three years, upon whom tracheotomy had been performed six months previously.

Professor WATSON showed the following, with the accompanying remarks:—

REMARKS ON SOME PATHOLOGICAL SPECIMENS EXHIBITED BY PROFESSOR WATSON.

I. (a). Hypertrophied and sacculated bladder, distended and tortuous ureters and immensely dilated renal pelvis, with several foci of suppuration in renal substance; from a man, æt. 63, who had been the victim of unrelieved prostatic obstruction, caused by a median tongue-like projection into urethra from an otherwise unenlarged prostate.

An identical condition having been observed at the necropsy of a late eminent London surgeon, who had overlooked, till it was too late, the full gravity of his own situation; an excuse may be made in the present case for the tardiness of this unfortunate bushman, in seeking surgical relief while there was still time.

(b). From the same patient an old and firmly united fracture of shaft of femur, showing fully three inches of shortening from over-riding of the fragments.

II. (a). Hypertrophied heart of a man æt. 28, who had suffered from insufficiency of aortic valves, and whose sudden death was occasioned by the "*syncope mortelle*," often observed under similar conditions.

(b). Dissected hand and bones of forearm from same individual.

The radius is the seat of a bye-gone Colles' fracture, in which the shaft has been actually telescoped into the cancellous tissue of distal fragment, the resulting impaction not having been interfered with, firm union has taken place, but unfortunately in a vicious position.

The hand of same side has also been the seat of some former injury, for which the middle finger and corresponding head of metacarpal bone have evidently been removed by amputation. On the dissected specimen the interossei muscles, in relation with the latter bone, are seen to have undergone an atrophic shrinking and fatty degeneration. The distal part of the bone itself is reduced by concentric atrophy to a slender pointed process, the apex of which represents the old section surface of the clipping pliers.

DEEP DRAINAGE AND WATER SUPPLY OF ADELAIDE.

The PRESIDENT (Dr. Davies Thomas), drew the attention of the members to the proposal on the part of the Government of placing the deep drainage and water conservation works under the control of a gentleman without any engineering education. It was, he thought, hardly necessary for him to remind his hearers how literally Adelaide had been a city of stinks until the system of deep drainage had been initiated; and how some portions of the town had formerly been almost uninhabitable on this account. He thought, that in the interests of the public health, the medical profession should protest against any action that might imperil the efficiency of the present drainage system. He could not but think that the proposed alteration in the department would be an injurious one, for not only was an engineer required still to complete the system, but one would be always wanted to see that it was kept in good working order. Then the present water supply was even now manifestly inadequate, and with the prospect of a speedy increase to the city and suburban population, fresh works would be required for this. He was glad to see that the City Council were alive to the importance of the matter, and intended waiting upon the Government with a view of protesting against the proposed change. He would like an expression of opinion from the meeting.

DR. LENDON agreed with the President that the matter was an important one, and would move that the Council of the Society form a deputation to the Commissioner of Public Works, with a view of ascertaining what provision the Government intended making to ensure the work of the deep drainage system and of water conservation being efficiently carried out. He would also add that the Council be asked to take any necessary steps, and if required to call a Special Meeting of the Society to further consider the matter.

DR. VERCO seconded the motion with the distinct understanding that they should first find out what the Government intended doing before they went so far as to take exception to its supposed action. The motion was carried unanimously.

PAPERS.—Mr. Anstey Giles read the following notes of a case in which the causation of the cerebral symptoms had been somewhat obscure:—

NOTES OF A CASE OF OTITIS.

By W. ANSTREY GILES, M.B. EDIN., LECTURER ON EAR DISEASES AT THE UNIVERSITY OF ADELAIDE, AND ASSISTANT-SURGEON ADELAIDE HOSPITAL.

I AM indebted to Dr. Hamilton, of Kapunda, for a case of ear disease, which I have watched very carefully for some time, and I think a few notes about the patient may interest some members of this Society.

W. J. B., æt. 51, resides in Kapunda, married. Consulted me first on the 25th January, 1888.

History.—When about 14 years old he suffered from an attack of measles, the result of which was an abscess in the right ear, and that, after causing great distress for a while, burst. After this he began to get deaf in the ear, the discharge continuing on and off, but he did not seek any medical advice. The deafness gradually increased till about five years after the first attack, when he discovered he was totally deaf in the affected side. He has always noticed that when the discharge stopped earaches supervened, and continued to trouble him until the flow was re-established. The amount of discharge has varied considerably, sometimes being so slight that he hardly noticed it, then without any apparent reason it would suddenly become very profuse. It was thin and watery, never blood-stained, and usually possessed an unpleasant odour. He has not been liable to sore throat, nor has he ever indulged in excesses with alcohol or tobacco. His general health has always been excellent.

In the beginning of December last he felt himself getting very shaky, he could not walk steadily, suffered constantly from giddiness, became sleepless, nervous, and his life was a burden to him on account of dreadfully loud and distressing noises in the ear. In spite of these symptoms, he managed to continue working in a timber yard (where he was placed in charge of the engine), but on the 2nd January, feeling much worse, he visited his medical man. The ear was treated with lotions and powders for ten days, when the discharge stopped suddenly, with the result that his general state became much more serious. Dr. Hamilton then kindly recommended him to come to Adelaide and consult me, which he did on the 25th January. The notes I took on the occasion were as follows:—"Patient, a broad-shouldered, powerful man, about middle height, with ruddy complexion. Is suffering intense pain in the right ear, and over the right side of the head. Speaks very thickly, intellect dull, and has to be addressed several times before he answers the question; is exceedingly restless. He will do

what he is told, but some of his answers are very incoherent. Continually muttering and talking about horses and steam engines, when asked to describe his symptoms."

I examined the right ear and found the inner part of the external auditory canal very red and swollen. It contained no pus. The pain was principally referred to the ear and the frontal and parietal regions. There was no redness or tenderness over the mastoid process, nor was anything to be felt behind the angle of the lower jaw. I could detect no hardness or swelling in the neighbourhood of the jugular vein. His temperature was normal, and Dr. Hamilton told me he had no rigors or fever while under his care. The throat revealed nothing abnormal.

I concluded there was pus pent up in the tympanum, and with Gruber's knife freely incised the posterior and lower part of the redness I took to be the tympanic membrane, and also made two deep incisions in the inflamed skin lining the external canal. I used a 10% cocaine hydrochlorate solution to deaden the pain. The bleeding which followed was very free. After this I advised his friends to take him to Mrs. Duncan's private hospital. There I had him put to bed and applied six leeches behind and in front of the ear. I directed that the ear should be syringed every hour with warm carbolic acid lotion and internally administered saline cathartics. His diet was milk and beef-tea. That evening pus began to flow, accompanied by great relief to the ear, but the pain continued in the head. Next day pus was flowing freely and the pain greatly diminished; his mental state, however, showed no sign of improvement; he was very restless, constantly jumping out of bed, and trying to escape by the door or window; I ordered warm cocaine drops for the ear, and the carbolic lotion to be continued; his reflexes were slightly exaggerated; there were no signs of paralysis, and sensation seemed the same on the two sides of the body. The pupils were medium size, reacted readily to light and accommodation, and no pain in the eyes was complained of; the sense of taste in the anterior half of the tongue on the affected side was impaired. During the next two days his condition remained much the same, except that the pain quite left the ear, and was complained of only in the frontal and parietal regions; his mental state was variable, at one time he would be comparatively rational, but half an hour afterwards would be almost unmanageable. The inflammation in the external auditory canal had to some extent disappeared, and several large granulations were to be observed on the posterior and inferior walls. In order to procure some rest for the patient, I ordered him paraldehyde (30 minims) in almond

mixture three times a day, which seemed to suit him admirably.

On the 29th January I asked Dr. Jay to see the case, and he agreed with me that nothing but expectant treatment could be recommended.

The same state of things continued till the 31st January, when the patient took a turn for the worse, became drowsy, his breathing was stertorous, he was with difficulty roused, and would not answer questions. In the afternoon I asked Dr. Thomas to visit him, which he did, but we could elicit nothing of importance, and the same treatment was pursued. The next morning he had rallied up wonderfully, would answer when spoken to, but was still semi-delirious. He had passed from a state of stupor into the restless condition previously described, and as he was also very noisy, in the interests of the other patients we had to move him to another abode, where his friends undertook to watch him day and night. I may here mention that during the whole time he was under treatment in the Private Hospital his temperature was taken every four hours and was invariably normal. After leaving the hospital his mind remained unsatisfactory; the ear discharged slightly, but very little pain in the head was complained of. Towards evening he always grew more excitable, and on the night of the 4th February he broke the windows of his bedroom, threatened those about him, and was so violent that his son was obliged to get a policeman and have him removed to the watch-house. The next morning I sent him into the Lunatic Asylum. Two days afterwards I saw him there, and found him quite insane. He talked a great deal of nonsense, keeping on assuring me that preparations were being made for his funeral. He said, just before my arrival the attendants had covered him with pitch and afterwards had hung him out in the sun to dry, so that he would burn rapidly when ignited. He was convinced that after my departure a match would be applied to him. He assured me he had already assisted in dispatching three inmates of the institution in a similar manner. I persuaded him to let me examine the ear, and this I found plugged with small pieces of newspaper, which I removed with-out difficulty.

On the 10th February, though not improved, his relations, having made other arrangements for his safe keeping, he was removed. A gradual and continuous improvement began on the second day, he gained strength, the giddiness decreased, he exhibited fewer signs of mental disturbance, and the tremors were not so severe. He took his food well, and at the end of the week was able to take care of himself. On the 15th, he said to me he would require to sell several houses to pay

my account as he was so long under treatment. I asked him how long he thought I had attended him, and his reply was "about 12 months."

I took down the following notes on the 9th April: Patient states he now feels quite restored to health. Can walk miles without feeling fatigued. There is no unsteadiness in his gait. He complains of occasional giddiness, but says it is trifling. He sleeps soundly all night, has an excellent appetite, and experiences no discomfort whatever in the ear or head. There is a slight discharge from the ear of thin colourless mucus, without odour.

His mind is perfectly clear and he talks rationally about his illness, but remembers nothing of what occurred at the private hospital, in fact, that period remains a blank to him.

The skin lining the external canal in its deeper part is thickened and red. Several granulations project from the posterior and inferior surfaces, which are soft and bleed easily when touched with a probe. No dead bone can be detected. The lower part of the membrane tympani is destroyed, and I was able to wash out the tympanic cavity with a Hartmann's canula, using a solution of boracic acid (gr. v. to oz.), but only a very small quantity of pus came away.

I passed the eustachian catheter but could not force any air through the tube. I subsequently removed the granulation with a curette and applied chromic acid (solid) to the part.

Remarks.—I do not feel at all certain about the marked mental aberration which lasted so long. During the first few days I suspected abscess formation, but now I do not imagine there could have been a localized collection of pus without more definite symptoms, nor do I think that the rapid recovery is compatible with that supposition. Abscess may form in this region without any marked rise in temperature, but there is usually less disturbance of the intelligence in cerebral abscess than in other diseases of the brain. Again, there was no intolerance of light, the pupils were invariably regular and the usual symptoms of abscess in the brain were absent. It is possible there may have been a localised meningitis, the inflammation extending to the dura-mater through the foramina in the bone. Dr. Jay and I both incline to this opinion. The idea might suggest itself that the insanity originated independently of the ear affection, but the absence of any other exciting cause, the freedom of any hereditary tendency, and the rapid and complete recovery, tend to go against this theory. With reference to the treatment, I endeavoured as far as possible to secure proper drainage of the tympanum, and to keep the parts thoroughly clean and dry. The only sedative I

allowed was paraldehyde, and this I kept up constantly till all symptoms had disappeared.

DR. DAVIES THOMAS remembered seeing the patient in consultation with Dr. Giles. He could not, however, profess to have been able to make any examination, owing to the great mental excitement of the patient. He thought there was great difficulty in the diagnosis of these cerebral lesions. A case he had at present exemplified this in a marked degree. There had been violent headache, vomiting of a cerebral character, right hemiplegia, paresis of right side of tongue and face, and ptosis, with exaggerated tendon-reflexes, but without any optic neuritis. These symptoms had gradually disappeared. He would certainly have felt inclined to have diagnosed a tumour.

DR. VERCO thought that the absence of high temperature in Dr. Giles' case precluded the idea of meningitis. He thought there might possibly have been a venous thrombosis.

THE PRESIDENT (Dr. J. Davies Thomas) then read the following two papers:—

ON THE DIAGNOSIS OF PULMONARY HYDATIDS.

By JOHN DAVIES THOMAS, M.D. LOND., F.R.C.S. ENG., PHYSICIAN TO THE ADELAIDE HOSPITAL, JOINT LECTURER ON MEDICINE AT THE UNIVERSITY OF ADELAIDE.

IN September, 1884, I read a paper before this branch upon hydatid cysts of the lungs; in that communication I endeavoured to submit to you a general review of the question; since that time, our knowledge has grown in this as in many other directions. It seems to me that in the diagnosis of this interesting and important affection we may report a decided advance, although we must still admit that some instances of this disease continue to baffle us.

The diagnosis of echinococcus of the lung has to be considered in two phases, viz., that of the unruptured, and that of the ruptured cyst.

Diagnosis of the Unruptured Cyst.—When deeply seated, and of small size, it must be admitted that a diagnosis is impossible in the present state of our art; but it is very doubtful whether, under such circumstances, patients often deem it necessary to consult a medical man.

I have heard of a case where a member of a medical man's family suddenly, one day, coughed up a small hydatid cyst, which had caused no suspicion of its presence, and which gave rise to no subsequent inconvenience. When the parasite is of considerable dimensions or superficially seated in the lung, the physical signs usually point out unmistakably the nature of the lesion. The principal signs are, as we all know, more or less deficiency of expansion of the affected region, which, however, rarely influences materially the mensuration; absolute dullness on percussion over a certain limited space, which usually presents

a more or less rounded outline; it is not influenced by change of posture of the patient. Over the dull region vocal fremitus is generally absent, although not always to the full extent of the dull area. In the affected spot there is generally total respiratory silence, or at most, very feeble respiratory murmur. Besides these signs there may be the pressure effects of a tumour, causing signs of centrifugal pressure, e.g., displacement of the liver, heart, spleen, etc. Occasionally the pressure effects are exercised in a mode quite different from that of pleuritic effusion, for example, a cyst of the left lung may push the heart bodily forward against the anterior chest wall, instead of displacing it in the lateral direction usual in left pleural effusion; again, in a case recently seen by me with Dr. Verco, a hydatid cyst of the right lung depressed the liver so that its lower edge reached three fingers' breadth below the costal margin, and yet the heart was scarcely perceptibly moved to the left. This is undoubtedly a physical sign of considerable significance, for as Dr. Douglas Powell* has remarked, and my observation agrees with his, displacement of the heart is a more important sign of pleuritic effusion than dislocation of the abdominal viscera, "in fact, displacement of abdominal viscera is no essential sign of pleuritic effusion, and is only present in extreme cases; whereas, displacement of the heart is an essential sign, and (unless prevented by countervailing causes) is present from the first in all cases of unilateral effusion." Often some such deviation from the normal type of the physical signs of pleuritic effusion will enable a differential diagnosis to be made.

Intermediate between those cases in which a small parasite is deeply seated, and those where a large cyst lies on the surface, is a third group, in which a moderate sized hydatid approaches the surface of the lung, but has a layer of that organ between it and the parietes. Here the typical physical signs of the pulmonary echinococcus are wanting, but still in some cases evidences of its presence are not wanting. The principal of these is an alteration of the percussion note, which becomes markedly tympanitic over a greater or smaller area. I drew attention to this character of percussion note in connection with unruptured lung cysts in my former paper on this subject, and I suggested that it was probably caused by compression of the lung between the cyst and the chest wall. Since that time I have observed it in several cases, among others, in a youth named Tuohy, now in the Alexandra Ward. In this patient, the posterior left base was occupied by a

* Diseases of the Lungs and Pleura, including Consumption Third Edition, 1886, page 81.

large hydatid, which, when the patient came under my care, had already been ruptured by a tapping operation performed in another hospital; nevertheless, in consequence of the existence of adhesions the sac had shrunk but little, and the portion of lung intervening between the cyst behind and the chest wall in front was compressed, and yielded a well marked tympanic note, which extended over the greater part of the infra-mammary, mammary, and even to a less degree of intensity into the infra-clavicular region on the left side, the heart was, of course, greatly displaced to the right.

A still more striking instance of the production of this tympanic note came under my notice lately in a boy, aged four years, whom I saw in consultation with Dr. Verco. Here, the only dull note present was found over a small area at the angle of the right scapula; over the greater part of the right back there was a well-marked tympanic note, which was also present in the axillary regions and over a part of the right front; there was also impaired mobility of the right side of the chest, and slight fulness in the right infra-clavicular region. The respiratory murmur was greatly enfeebled over the region of tympanic resonance, and in places it was almost inaudible, but there was nothing resembling the usual auscultatory signs of a cavity. For the production of this note, it is not even necessary that the parasite should invade the lung tissue, for I have observed it over a limited area in a case where a hydatid of the convex surface of the liver compressed the lower edge of the right lung in front, near the sternum. In this case it disappeared after the cyst was operated on. A tympanic percussion note is not peculiar to deep-seated hydatids of course, for any deep-seated tumour which compresses the lung, *e.g.*, an aortic aneurism may also produce it. Of course I allude to the tympanic note not connected with any cavity, signs, or indications of pneumothorax.

The Diagnosis of Ruptured Pulmonary Hydatids.—In the majority of these cases, the diagnosis is rendered easy by the expectoration of threads of membrane of the characteristic kind, but in some cases no such evidences are forthcoming for our assistance; the diagnosis then has to be made on other facts. In the case of hydatids rupturing into the pleura, the entire parasite may escape into the pleural cavity and then, of course, no shreds can be expectorated. In the majority of cases, it is not difficult to determine in a patient with a ruptured pulmonary cyst, where in the lung the remains of the bladder-worm are; but in some instances this appears to be impossible.

In illustration of this assertion, I may cite the

case of Mr. C. This gentleman gave me the following history of his case on December 30, 1887. He enjoyed good average health until about 15 or 18 months ago, when he was seized with a "stitch" in the neighbourhood of the right nipple; at first he attributed this pain to the vigorous use of dumb-bells, but as it persisted, he consulted Dr. Hayward. At this time, I believe, no local cause for the pain could be discovered; the pain continued to increase in severity for about a fortnight, when signs of fluid at the bottom of the right chest appeared, and he was tapped by Dr. Hayward, and pleuritic fluid was withdrawn; no relief to the patient followed this operation, and three weeks later a second puncture was made. The first tapping was made at the back of the chest, the second in front; by the latter, about half-a-pint of hydatid fluid was removed. Shortly afterwards, a third puncture, near the seat of the second one, was made, but no fluid came away. I saw him with Dr. Hayward in consultation, but on this occasion no physical signs pointing to the locality of the cyst could be discovered. After this time he continued apparently well, with the exception of an occasional slight cough, for about a year. His cough then became worse, and he sometimes expectorated blood and sputum of offensive taste. He then consulted Dr. Way, with whom I saw him on December 30, 1887. The patient further stated that for about two months past he had been coughing up large shreds of hydatid membrane, but that recently there had been no hæmoptysis; the general character of the expectoration was muco-purulent, and it was generally moderate in amount, but now and then it amounted to perhaps, a quarter of a pint per diem. The physical examination showed scarcely a trace of anything abnormal; the liver was of normal dimensions, and in its normal situation; there was no abnormal dulness anywhere, in fact, the only discoverable suspicious symptom was a doubtful area of hyper-resonance about the angle of the right scapula. The respiratory murmur was everywhere of normal character and loudness. This case well exemplifies the occasional difficulty in the localisation of pulmonary hydatid, even when the fact of its presence is undoubted.

A still more embarrassing group of cases are those in which the very presence of the parasite is doubtful, and when the symptoms closely simulate those of phthisis. When the cyst is small, ruptured, and centrally seated in the lung, I believe that at present we must regard the diagnosis by ordinary physical signs as impossible. However, when the diagnosis lies between phthisis and suppurated hydatid, the examination of the sputum for the tubercle bacillus is an invaluable

aid to a correct conclusion as to the existence of tuberculosis; of course the possible co-existence of the two diseases must not be overlooked.

In two cases recently, I have had the opportunity of examining the sputa in cases of suppurated pulmonary hydatid, and in neither was there the slightest indication of the presence of any bacilli that could be mistaken for those of tubercle. I have employed various kinds of stains *e.g.*, Gibbes's magenta and nitric acid process; Gibbes's "quick" stain, Ehrlich's aniline-oil and fuchsine stain, etc., but always with a negative result as regards tubercle bacilli in cases of pulmonary hydatid.

SMALL HYDATID OF THE RIGHT LUNG—RUPTURE INTO PLEURA—PNEUMOTHORAX—OPERATION—CURE.

HERBERT S., aged 6, resident in one of the suburbs of Adelaide, was admitted into the Alexandra Ward of the Adelaide Hospital on Nov. 9, 1887.

No satisfactory history of his case could be obtained; but his mother stated that he had suffered from a cough for some time, and that, about ten days before his admission into the hospital, he had a sudden attack of cough and difficulty of breathing, in which he brought up blood from his mouth and nose.

Before he came under my observation, he had been seen by Dr. Hayward, who found evidences of pleural effusion.

On admission, he had marked dyspnoea, but no cyanosis; the right chest showed bulging and deficient expansion; the percussion note over the entire right side of the thorax was tympanitic, and the normal hepatic dullness was entirely absent; the respiratory murmur was feeble, and the voice sounds had a metallic echo; the bell sound was well marked. At this time there were no signs of fluid in the pleura; on the left side there was puerile respiration; the apex-beat was felt in the 7th left interspace in the mid-axillary line.

Dec. 1.—*Operation*: Ether having been administered, an incision was made in the right scapular line over and into the 8th interspace; when the pleura was opened a small quantity of turbid, spontaneously-coagulable fluid escaped, and a slight sound of issuing gas was heard; the gaseous and liquid contents of the pleura were free from any offensive odour. Evening—Temperature normal.

From this time, until about the 18th day, the temperature ranged from normal to 102°, the evening temperature always being the higher; there was no dyspnoea when the patient lay quietly in

bed; the discharge from the pleural cavity was small in amount, serous in character, and it continued aseptic.

The dressing used in the early part of the treatment was a large pad of picked oakum, on one surface of which a layer of Hartmann's wood wool about half-an-inch thick was spread—the whole being enclosed in a layer of carbolic gauze to form a pad. Only one such dressing was needed each day.

After the 18th day, the temperature fell to normal and so remained, except for about a week, when it rose somewhat, the highest temperature recorded being 101.6°.

On January 7, 1888, it was noted that the lung was expanding, and that two pieces of hydatid cyst-wall were found in the dressing. Two days later, Dr. Aitken (the House Physician) remarked that the percussion-note over the right chest was nearly normal, and that the respiratory murmur was audible, although somewhat weak. The heart also had returned to its normal site.

On January 26 the drainage tube was finally removed.

On February 2 he left the Hospital apparently well.

DR. A. A. HAMILTON said the difficulty of localizing an hydatid cyst known to exist in a lung, is exemplified by the case of a girl of about 10 years of age, whom he attended 4 years ago. Her only symptoms were repeated attacks of hæmoptysis, during which she lost sometimes as much as $\frac{1}{2}$ or $\frac{3}{4}$ of a pint of blood. After each attack the loss was made up with great rapidity and she continued in apparently perfect health. The family history was good, and Dr. Corbin, who saw her with him, agreed that the hæmorrhage was due to an hydatid cyst, which, however, they were unable to localize. Ultimately she spat up some fragments of hydatid membrane, and recovered perfectly. Curiously enough, just as she was recovering, her mother began to spit blood in small quantities, and to suffer from cough. She spat up a quantity of daughter cysts, and also recovered perfectly. The mother and daughter had paid a visit some time before to a station up country, where no doubt, they had both become subjects of the disease.

Mr. HAYWARD agreed with the President that, at times, it was very difficult to diagnose pulmonary hydatid, especially when the case was complicated with some intercurrent pulmonary disease. In the case mentioned by Dr. Thomas, which had been under his care prior to his (Mr. Hayward's) visit to England, the patient had presented himself complaining of slight though persistent pain over the region of the upper part of the liver; there were no physical signs present, and as there was a history of somewhat unusual muscular exertion, myalgia was diagnosed. Three weeks later the patient again presented himself, and stated that there had been no amelioration in the symptoms. On this occasion a dry friction rub could be detected at the base of the right lung. A week later there was evidence of pleural effusion. This not subsiding, aspiration was performed, the needle being inserted posteriorly and a quantity of typical effusion withdrawn, with the result that the dulness on percussion over the lung cleared up, with the exception of a limited space

just under the right nipple, which persistently remained. Under the impression that it was a collection of pleural fluid bound down by adhesions, aspiration was again resorted to, and about half-a-pint of hydatid fluid withdrawn. After this the patient began to improve and put on flesh, though the localized dullness never quite cleared up, but no more fluid was able to be withdrawn at a subsequent aspiration. Mr. Hayward had noticed the presence of increased resonance on percussion in cases of pulmonary hydatid, but had generally noticed it to be accompanied by the sensation of increased resistance. The speaker drew attention to a possible danger after successful operation in these cases, as exemplified in a case that had been under his treatment:—This patient, an anæmic and badly-nourished young woman, suffered from a very large hydatid tumour which, by pressure, had caused consolidation of the left lung. The chest was opened, a rib resected, and the parasite removed. As the resulting cavity contracted the lung began to expand, but tubercular action soon supervened and a large cavity formed, followed by general pulmonary tuberculosis; and two days after the external wound healed, the patient succumbed—ten weeks after the date of the operation.

DR. VERCO thought that hæmoptysis in children meant hydatid disease in nine cases out of ten. Hæmoptysis without loss of strength generally pointed to hydatids. Sometimes the presence of the parasite excited the surrounding lung and set up inflammation, which passed through the different phases of pneumonia. He agreed that the tympanitic note was an altered one—somewhat duller, with a certain feeling of resistance. He had a case of pneumonia of the apex complicated with hydatid of the same region. The inflamed tissue had apparently not interfered with the nutrition of the parasite, as the aspirated fluid was perfectly clear.

MEDICAL SOCIETY OF QUEENSLAND.

THE ordinary monthly meeting was held at Brisbane on March 12, in the School of Arts.

Present: Drs. Little, Neil, Gibson, Tilston, Hardie, Connolly, Jackson, Clowes, Lyons, McNeely, Taylor, and Love.

The minutes of last meeting were read and confirmed. Correspondence with the Pharmaceutical Society re interchange of courtesies, co-operation in legislative matters, etc., was read.

The motion put forward by Dr. GIBSON, and seconded by Dr. BYRNE, to the effect that "Any member who wishes to bring before a general meeting of the Society the professional merits or demerits of any candidate for membership shall be at liberty to do so" was then discussed freely, Drs. GIBSON, NEIL, MCNEELY, TAYLOR, TILSTON, and LITTLE taking part in it. After opinions had been thoroughly ventilated on the subject, Dr. Gibson agreed to withdraw the motion.

Dr. LITTLE gave notice that he would move the following resolution at the next general meeting: "That the Medical Society of Queensland considers it necessary that the State should provide control of chronic inebriates, other than sending them to gaol or waiting till they have qualified themselves for admission to a lunatic asylum."

Owing to the lateness of the hour Dr. Dunlop's paper was again postponed.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number. All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, MAY 15, 1888.

EDITORIALS.

QUEENSLAND, "A SHOCKING EXAMPLE" OF AUSTRALIAN QUARANTINE.

SOME months ago we published an article on Queensland Quarantine, the truth of which has been only too well verified. Since then another case has occurred of a ship having measles existent on board being granted pratique at all the coast ports except Thursday Island. The S.S. "Dacca," to which we refer, not only arrived in Brisbane with a case of measles among the saloon passengers, but the Health Officer, Dr. Wray, not feeling justified in passing the ship, wired to the Premier for instructions, and Sir Samuel Griffiths, himself the framer of the present Act which provides fourteen days' quarantine for measles, actually wired back granting pratique. At the present time measles are prevalent in every coast town, and are almost epidemic in Brisbane. In the "Dacca's" case the result was very remarkable. The immigration agent, Mr. Parry Okeden, had occasion to visit the child who was ill on board, and he became infected and had a severe attack of measles. Nor did it cease with him, for his wife and all his children have been down with the same complaint. How many similar instances can be traced is a matter for grave consideration, and only tends to prove the truth of what we said in a previous article,

viz.:—"Either let measles be omitted from the list of diseases for which quarantine is imposed, or let the Act be carried out in its entirety." The present mode of administering the Act in Queensland is a farce, with a very fair amount of solemnity in it, when we come to consider how many centres of contagion have been created through it. Can no one be found amongst the various Ministers of the Crown in the different colonies who will take up the subject of Federal Quarantine? In these columns we have frequently pointed out the absolute necessity for union on this important subject. Quarantine laws vary in each colony, their mode of administration also varies very considerably, and in some instances, as in Queensland, portions of the Acts are almost dead letters. Surely the time has come for concerted action to protect our shores against the divers contagious and infectious diseases which cause such deadly epidemics in older countries. Traffic with Europe and the East is rapidly increasing, and there can be no doubt that unless speedy steps be taken cholera and small-pox will eventually find their way into the colonies, not in isolated cases as they, up to the present, have done, but in a form that will render an epidemic inevitable. Once established and their footing made sure, cholera and small-pox germs are not easily eradicated and no amount of legislation in the direction of Federal Quarantine will then avail. The present is the only time, let us, therefore, urge upon the various medical bodies the necessity of agitating for a Federal Act. It seems self-evident that good and sufficient quarantine stations should be erected at the three ports of first call for foreign vessels, viz.: Albany, Port Darwin, and Thursday Island, for it is at these ports that nine-tenths of our immigrants first have communication with shore. Next there should be a staff of really competent Health Officers at each of these ports. Two would at least be required, for in the event of the boarding officer finding contagious disease on a vessel it would be his duty to go into quarantine with the cases then existing. All cases or suspected cases could be at once removed to the quarantine station, the clothing of all on board fumigated, and the vessel placed in quarantine, if the disease were cholera or small-pox. If any of the lesser contagious diseases, the ship might proceed, care being taken at each port of call to exercise a careful discretion in allowing people to land. In mentioning Albany, Port Darwin, and Thursday Island, we wish it to be distinctly understood that it is not at these places themselves that quarantine stations should be established, but at some convenient locality near them, which would place the towns already existing out of all danger of

contagion, and at the same time be within easy communicable distance from those ports. The main contention for which our profession should agitate, and which all feel to be the only correct one, is that the quarantine should be performed at the first port of call. It would be better for the shippers, shipowners, and passengers, for in numerous instances the quarantine to be undergone would, on the whole, be considerably shorter, as the infected people would be at once removed and the danger of fresh cases springing up and sowing fresh centres of contagion during the passage along the coast lessened very materially. Lastly and not least, the patients themselves would have more chance of proper attendance, nursing and comfort, for these things are hard to be obtained even on the best regulated ship. There are many more points, but for the present space prevents us from putting them forward, but unless some move is made in the matter we shall return to the subject again, and not let it drop until we can see some very considerable improvement in the methods adopted for protecting the Australian Continent from the invasion of contagious disease.

PRAISEWORTHY ACTION OF THE QUEENSLAND MEDICAL BOARD.

APPENDED will be found an interesting résumé of the proceedings of the Queensland Medical Board in regard to three persons who have obtained registration by the Medical Boards of various Australian colonies. Two of them had been registered in Queensland, but the third, as will be seen, was only an applicant for registration in that colony. We congratulate Dr. Bancroft, the President, and his colleagues on their practical acumen and commend the caution which they exercised. Though no more than the public has a right to expect from such a body, it has exhibited such a marked contrast to that of New South Wales that it becomes worthy of remark. We would point out that the Queensland Medical Act gives no greater power to the Board than that possessed by New South Wales, but its members have the courage of their opinions and do what is necessary for the public interest, leaving the legality of their action to be tested by the men removed by proceedings in the Supreme Court, should they be venturous enough to try it. It will be seen that the Medical Board in Brisbane received

every assistance from the Premier and the Crown Law officers, and in this and this only has it been in a more advantageous position to take action than its analogue in Sydney, who, as was shown before the recent Select Committee, have never received the slightest aid from the Government. We can only hope that the New South Wales Board, having the example of that of Queensland before its eyes, will follow the example and act promptly in the same cases, for the names of two of the three persons who were dealt with are still on the medical register of the former colony, and their being allowed to continue there will be a wilful deception of the public by the very body which was created to protect them from such frauds. There are other cases equally bad in New South Wales well known to the board, and it is but right that they should be dealt with in the same way. We fear that sufficient caution is not exercised as to the identity of individuals applying for registration, for, if we are not greatly mistaken, we think that only recently a man has been registered who is not the rightful possessor of a genuine diploma. The course which a Medical Board ought to take in all doubtful cases, we have no hesitation in saying, should be to refuse to register the diploma until better evidence of the genuineness of the diploma and of the identity of the applicant is forthcoming, at the same time informing the person to whom registration is refused that he has the Supreme Court open to him where he can make application for a mandamus compelling the Board to register him should he produce sufficient proof to that Court.

The following interesting details will disclose the facts of the cases referred to :—

THE CASE OF SIDNEY EDWIN HERBERT.

On 25th October, in consequence of an application made for registration, and certain suspicious circumstances which had come to light, the following letter was addressed by the president of the Queensland Medical Board, Dr. Bancroft, to the Registrar of the Royal College of Physicians, Edinburgh :—" Sir,—I have the honor, by direction of the Queensland Medical Board, to request you to be good enough to give your attention to the following matter, and to reply at your earliest convenience, so that the Board may be in a position to deal with the case. In May of this year one 'Sidney Edwin Herbert' presented the licentiate's diploma of your college, granted in the year 1879, and claimed registration thereon in this colony. He at the same time made a solemn declaration before one of the local magistrates to the effect that he was the person named on the diploma. The Board registered him on the

strength of the documentary evidence brought before them, but before his papers were returned to him certain information reached the Board, throwing grave doubt upon the man's identity. The board, therefore, decided to retain his papers and to communicate with you, of which action Mr. Herbert has been apprised. I beg to enclose a photo of the original diploma, and shall deem it a favour if you will advise me whether any such person as Sidney Edwin Herbert passed his examination and received the licentiate's diploma of your college during the year 1879."

Mr. Herbert's explanation in reply to the Board's request for evidence as to his identity was contained in a letter dated 20th October, in which he says :—" At the time of my presenting myself at Edinburgh for examination, and also whilst studying there, I was entered on the college books under the name of Sidney Edwin Duncan. This was at the time, and under the circumstances to be detailed, the only name I could legally bear. It was my mother's maiden name. My poor father, in the year 1870, met with a violent death in Greece, in the service of his country. On the news arriving in England, my uncle, his younger brother, immediately instituted a suit at law contesting my dear mother's marriage, and mine and my sister's legitimacy. Whilst the trial was pending—it was in Chancery—my mother and ourselves (myself and sister) took her maiden name. At last, after twelve years' duration, the suit, in which all my father's personal property was involved, he having been intestate at the time of his assassination, was concluded, and in our favour, and I became entitled to the name which I now bear. I then wrote to Dr. Wylie, the then secretary of the Royal College of Physicians, Edinburgh, and told him that I wished to alter the name on my diploma to the name to which I had always been rightfully a claimant. He sent me an answer to San Francisco, telling me that I might do this, and that if in the future any question of the matter should arise, he would bear it—the alteration—in mind. For corroboration of this I beg to refer you to him, if he be still in existence, and also to Mr. A. Fisher, Gray's Inn, London, who is our family lawyer. I am sorry that I have not Dr. Wylie's letter in answer to mine, as I could have sent it; but in my travels since that it has been mislaid. I was at the time of its receipt in the American naval service, which I left in Melbourne in the latter end of 1882."

Another letter was sent by Mr. Herbert from Muttaborra in reply to a further communication from the Board, and on 2nd February, 1888, a reply was received from the Secretary to the Royal College of Physicians, stating that "Among

the licentiates of this college there is no one named Sidney Edwin Herbert." A list is also given of the nine gentlemen who obtained the license of the college on the 4th December, 1879, the date of the diploma produced by Herbert, but neither his present name nor that of Duncan appears. The secretary adds, "The photograph which you have forwarded to me, has without doubt the correct signatures of the then President and Secretary, and the date is quite as undoubtedly in the handwriting of the deceased officer of the college. But I am of opinion that the name Sidney Edwin Herbert is not in the handwriting of the late officer, and am inclined to think that from the appearance of the photograph there has been an erasure of the original name on the diploma, with the substitution of the name now standing thereon. Of the nine gentlemen named above, eight are in this country. One—Mr. John Rutherford Ryley—went to New South Wales, and resided at Temora in that colony. I may be allowed to suggest that it might be of interest to find whether Mr. Ryley is still at Temora, and, if he is, whether he still has the diploma granted him on 4th December, 1879. It is possible that on the decease of Mr. Ryley, if such an event should have occurred, his diploma might have passed into other hands, and undergone certain alterations."

The Secretary of the Queensland Medical Board, in a letter to the Crown Solicitor, dated 14th February, briefly recounts the circumstances of the case already disclosed, adding that "The John Rutherford Ryley alluded to died in Sydney on 3rd March, 1884. The Medical Board have recommended that Herbert's name be struck off the roll of medical practitioners; they have also requested me to communicate with you and to obtain the Attorney-General's opinion as to whether any further action can be taken against Herbert, who is at present practising medicine in this colony."

In reply to a further communication from the Medical Board, a second letter was received from the Secretary to the Royal College of Physicians, Edinburgh, in which the following occurs:—"The explanation given by him (Herbert) although highly plausible is yet eminently unsatisfactory, inasmuch as it is destitute of any basis of fact. In the book of signatures I find that on 5th February, 1879, the diploma of Licentiate was conferred on Sydney Edward Duncan. But this gentleman is at present a surgeon in the army. His diploma bears date (as above mentioned) of 5th February (not 4th December), and the Christian name is Sydney Edward, not Sidney Edwin. . . . My predecessor, Dr. John Wylie, informs me that there is absolutely no

truth in the statement [that the diploma was obtained under the name of Duncan]; and I may add that no change of name is ever allowed to be made in the way described by Mr. Herbert. When a fellow, member, or licentiate has changed his name, he is required to produce a deed of poll, or solemn affidavit, along with his diploma, and thereupon the Council gives authority to the President and Secretary to endorse upon the margin of the diploma the new name of the licentiate, leaving the old name as originally filled in."

Herbert's name was struck off the medical list as notified in the *Government Gazette* of 4th February. He was in November last employed as surgeon of the Muttaborra Hospital

J. G. A. ZIEHLKE'S CASE.

The Medical Board has also dealt with the case of Julius Gustav Adolph Ziehlke, who on the strength of his declaration that he had studied medicine at the University of Berlin for six years, and in 1865 obtained diplomas for medicine and surgery (which, however, had been mislaid or lost), had been registered in New South Wales and South Australia. He presented a copy of his diploma to the Queensland Board on the 5th of August, 1887, but registration was refused pending inquiry. The papers were submitted to Dr. Lauterer, of South Brisbane, a German medical practitioner, who gave it as his opinion that they were not sufficient to enable any man to practice medicine in Germany, as it was necessary that a "staats examen" (States examination) should first be passed. Moreover, the letters written by Mr. Ziehlke in his native language did not show that he was an educated man. In the meantime, Mr. Ziehlke received the appointment of medical officer at Maytown, on the Palmer. The Medical Board finding that his papers were not all that was required, communicated with the Hospital Committee at Maytown, and apprised them of that fact. In reply, the Secretary, under instructions from the Committee, wrote saying:—"Previously to electing Dr. Ziehlke as medical attendant at the hospital, the Committee had ascertained from official documents that he was a M.D. of the Berlin University, a degree which ranks as high as any in Europe. The Committee further satisfied itself that the doctor is registered as a medical man in South Australia and New South Wales, having passed the Medical Board of each colony. Since his arrival here I am instructed to say that Dr. Ziehlke has shown his ability on several occasions, and given the greatest satisfaction to the Committee. The Queensland Government have also been pleased to appoint him medical officer at

Maytown, and accorded him his rightful title of M.D., as you may ascertain by referring to the *Government Gazette*. Under these circumstances the Committee, while thanking the Medical Board for their information, desire me to state that they have not the slightest intention of dispensing with the services of Dr. Ziehlke." Mr. Ziehlke was also communicated with by the Board, and in reply to the inquiries instituted, he said:—"I left Germany at the end of 1869, having for good reasons deserted from the 3rd Regiment of Hussars in the Prussian army, and came to Melbourne in the ship *Somersetshire*. I have since held appointments in various Australian colonies.

I was also hospital doctor at Maytown till I resigned. On reference to the accompanying *New South Wales Gazette* for 1887, your board will see certain names of German medical practitioners. . . . and will further see how very few of those gentlemen hold the State certificate, which I certainly held, although of inferior value to a university degree, and a duplicate of which I cannot obtain because of my desertion as aforesaid. A duplicate of my university degree I can at any time obtain on payment of a fee, and I am still a graduate of the University of Berlin." The board then requested the Hon. J. C. Heussler, German Consul for Queensland, to bring the matter before the authorities of the University of Berlin, and the report received was: "According to a report of the medical faculty of the Berlin Friedrich Wilhelm University of the 20th December, it appears that J. G. A. Ziehlke has neither studied nor has he been promoted to the *Doctor medicinae* at that institution; likewise has been ascertained from the books kept for that purpose by the minister for spiritual education and medical matters that no person of the above name has undergone the medical Staats-examen at the Prussian Examination Commission. The assertions of J. G. A. Ziehlke are consequently not sustained by facts." Before the receipt of this letter, however, the matter had been settled by the following communication, dated Tallegalla, September 29, 1887:—"The Secretary of Queensland Medical Board. Sir,—Herewith I withdraw my application for my registration to your Board. As I leave Australia on the 17th October for Germany with my family, I hope you will excuse me for all the trouble I gave you.—I am, sir, your most obedient servant, J. ZIEHLKE, M.D."

RICHARD THOMAS FREEMAN.

In 1875, a man styling himself Richard Thomas Freeman, was registered as a medical practitioner in this colony, and since then he has practised in various parts of Queensland as such. The first doubt thrown upon Mr. Freeman's identity was in the evidence of Andrew Houison, M.B., given before the Select Committee appointed on the motion of the Hon. J. M. Creed, by the Legislative Council of New South Wales to inquire into the laws respecting the practice of medicine and surgery. Mr. Houison said that there had been a man named Richard Thomas Freeman practising in that colony whose name was Walter Alfred Freeman. This man had been registered on a genuine diploma in the name of Richard Thomas Freeman. Mr. Houison added that the Board had attempted to prosecute Freeman for fraud, and a complete chain of evidence had been obtained, but the Attorney-General, Mr. Want, had said that he could not advise them in any way. Upon seeing this evidence, and being aware that Freeman had since been registered and was practising in Queensland, the Medical Board here communicated with the Secretary of the college from which Freeman's papers purported to have been issued. It was then found that only one man of the name had passed through that college, and he was identified as Dr. R. T. Freeman, who was in practice in London. He had never left England, and knew no medical man of the same name as himself, but he stated that sometime previously on going through his papers he found that his license from the College of Physicians of Edinburgh, obtained in 1865, and also his certificate of registration were missing. Upon receiving this information the Board wrote to Mr. Freeman, who is at present practising as a medical man in Croydon, and asked him to explain these circumstances. He replied stating that he was the proper holder of the diploma under which he was registered, and referred the Board to the fact that he had held the position of surgeon on board of several immigrant ships which had come out to Brisbane and Rockhampton prior to the date of his registration. As no further explanation was forthcoming the Board forwarded all the papers connected with the case to the Chief Secretary. After perusing them Sir S. W. Griffith addressed a memorandum to the Board, giving it as his opinion that there was not sufficient evidence for a prosecution, but ample to justify them in removing Freeman's name from the register, which advice has been followed by the Board.

LETTERS TO THE EDITOR.

AN OPERATION ON THE PENIS BY
ELECTROLYSIS.*(To the Editor of the A. M. Gazette.)*

SIR,—Mr. S., age 26 years, had suffered since birth from an imperfect urethra. In his case, the entrance to the urethra was situated on the under part of the penis, one inch from the point of the glans, otherwise the form of the organ was quite natural. There was a shallow slit at the end of the glans, where the meatus of the urethra is usually found, but from it to the urinary orifice described the part of the penis was quite firm, and to the touch similar to the corpora cavernosa, and it resisted the passage through it of any size probe, either from above or below. I had never seen a similar case, nor heard of one.

The man was anxious to marry, but was afraid to commit himself under the circumstances. He had consulted several surgeons, and was told nothing could be done for him. Having performed several successful operations by electrolysis, I was resolved to try electricity for this one, and succeeded far beyond my most sanguine expectations, as the following will show.

Most medical men, I presume, know the physiological and therapeutical effects of electricity upon the mucous and other tissues of the human body, and that being so, it will be unnecessary to extend my letter in describing it here, beyond the reference to a few chief points. If the Faradic current be employed with metal electrodes (or a sponge electrode as positive, and a metal electrode as negative), we know that the two poles are identical in their action, and manifest no material difference, at least, it is not so marked as in galvanisation. If the latter process be used, with metal electrodes to obtain electrolytic action, the result will be widely different. The positive pole will be noticed to coagulate the blood, and attract acid and oxygen. The battery, by producing this acid product, acts as actively, and produces as painful and sloughing a sore as will the most powerful mineral acid, and leaves behind a hard and retractile cicatrix on the tissue with which it has been in contact; while the negative pole will dissolve blood, attract hydrogen, coagulate albumen, attract alkalies, and act as a caustic alkali on the tissues, leaving behind a small soft cicatrix, which is not retractile.

The above must be understood for the intelligent application of the method under consideration. We must understand, too, that each case depends on its own inherent peculiarities, and must be treated accordingly. What is required in

electricity is careful observation, study, and practice, and relief, both in medical and surgical cases, may be afforded in many instances which have baffled the wisest surgeons and physicians. A little careful observation in electrolysis will plainly show its action is simply a galvanic chemical absorption, mainly depending on chemical decomposition, caused by electrolytic action. Webster's definition of absorption is as follows:—"The process or act of being made passively to disappear in some other substance through molecular or other invisible means, as the absorption of light, heat, electricity, &c.," and such is the action in this case exactly. As the negative pole acts as a caustic alkali, if great tension is used, it will destroy tissue, but mildly applied it acts as a chemical absorbent on tissue.

Having performed several minor operations by electrolysis very successfully, in addition to this one now under consideration, I am convinced that electrolysis in surgery is of inestimable value, for by no other means that I know of could this man's urethra have been extended to the end of his penis without a hard and retractile cicatrix forming, and closing up the passage again, in spite of bougies or any other appliance that might be used with a view of keeping it open.

The *modus operandi*:—First, the patient was placed on an operating chair. No anæsthetics were administered. The substance to be penetrated being of a firm and fibrous nature, and offering great resistance, considerable tension was required. A sponge electrode was attached to the positive pole of a Leclanché battery, and a No. 4 catheter was then connected with the cord electrode of the negative pole. The catheter was next gently pressed into the shallow slit at the end of the penis, and the current was completed by placing the sponge electrode firmly in the patient's hand. The current was gradually increased from zero to 20 cells, on account of the firmness of the texture to absorb. Generally from 8 to 10 cells are adequate where the tissue is less firm. Soon afterwards a frothy, yellowish mass, like coagulated albumen, surrounded the point of the catheter in contact. This product was part of the tissue which had been decomposed by the electrolytic action of the battery. In 20 minutes the catheter had penetrated to the extent of a quarter of an inch. It was then withdrawn, and the cord electrode was fixed to a large silver probe, and its pointed end was very gently pressed into the bottom of the passage opened out by the catheter. The cells were reduced to 10, and in 10 minutes a passage was established right into the urethra, situated one inch from the point of the glans. The pointed end of the probe was removed, and the bulbous part substituted.

In a few minutes it had worked its way through the new passage well into the urethra. The probe was then altogether removed, and the No. 4 catheter again used as at first, but with only 10 cells of the battery, and in eight minutes this instrument passed down into the urethra, making for itself a clearly established passage. Wet lint was then applied round the penis, and the patient sent home. Seven days afterwards a No. 7 catheter was passed by the electrolytic action into the urethra from the point of the penis, and on the seventh day again a No. 11 was readily run through the new passage into the bladder. Twenty-eight days after the first operation a No. 11 catheter passed with the greatest ease. All discharge had ceased. The lining membrane of the new part was quite pliant and patulous, exactly resembling an ordinary mucous surface, showing how readily membranes change and adapt themselves to circumstances. Again, a mucous lining will soon assume a cuticular quality when exposed for a short time, which occurred to a part of the upper lip of another patient, the central portion of which I cut through and turned up to build the lower columnar part of a new nose. The lateral surfaces and dorsum were taken and formed from the skin of the man's forehead.

Referring to the electrolytic operation, I should remark that no untoward symptom occurred in any way to interfere with the steady progress of the case. A bougie was passed occasionally, but there were no indications of any contraction. The urine passed perfectly freely through the new part without any pain or irritation. The old outlet is now contracted—six weeks after the operation—to a very small hole, and only a few drops of urine ooze through it during micturition. Later on it will be closed by horsehair sutures. So far, this operation by *ELECTROLYSIS* has been an undoubted success, and appearances the last time I saw the patient (speaking reservedly) indicated a permanent and most satisfactory result.

I am, &c.,

JOHN WILKINS, F.R.C.S.

Auckland, New Zealand.

TRACHEOTOMY IN DIPHTHERIA AND CROUP.

(To the Editor of the A. M. Gazette.)

SIR,—Dr. Affleck Scott, of Maryborough (Victoria), inquires in the March issue of the *A.M.G.*: "Should not the operation be performed, not for the disease but for laryngeal obstruction, and for that only?" I certainly am of opinion that the operation is only advisable for the relief of obstruction, and can only benefit the disease so far as by its means better oxygenation of the blood is obtained.

I also think that the early operation is advisable in all cases in which laryngeal obstruction is rapidly increasing.

Yours, &c.,

F.R.C.S.

A SEVERE MIDWIFERY CASE.

(To the Editor of the A. M. Gazette.)

SIR,—The following case occurred in my practice lately, and might interest some of your readers:—Mrs. S., æt. 27, multipara, was taken ill on 6th February. The midwife sent for me in a great hurry, and desired my presence at once. I found pains very strong, with great bearing down, right arm and shoulder presenting, hand appearing at vulva. Midwife told me the waters had come away before she arrived. I tried to get hand and shoulder back, but as the bearing down increased I was afraid the shoulder would get fixed, so emptying the bladder I administered chloroform to complete insensibility. Having then well oiled my hand and arm I worked it gently up the canal and through the os. The uterus then contracted firmly, and for some time my hand was powerless owing to its being so cramped. I, however, kept it well pressed against the child for fear of lacerating the uterine wall, and after great difficulty I seized a foot and used traction, pushing head upwards from without. As this was very slow I passed a noose of tape round foot and made traction downward and backwards, and with the other hand I pushed the shoulder through the brim; gradually the body turned, and the legs descended and were born. Some little difficulty occurred with the head, but with slight traction it was overcome.

Child born at 2.40 a.m., with limbs flaccid, surface cold, heart not perceptible, so I immediately tied the cord, cleaned out the mouth, and had the child dipped into hot and cold water alternately; but as this seemed to do no good, I commenced artificial respiration, which was kept up for twenty-seven minutes, when there was slight twitching of mouth muscles, which was soon followed by convulsive gasps, and gradually the respiration improved. For two days the child was very weak, but afterwards it became strong and healthy. As the placenta did not come away at the usual time I removed it at 3.25 a.m., several large clots coming with it. Left at 4.30 a.m., patient sleeping soundly—effect of the chloroform. I was greatly hampered at not having an assistant to give the anæsthetic, the case extending over five hours. However, I had a very clever, smart, and experienced nurse, who was of much service and relieved me greatly. I mention this last fact, as it has seldom occurred in my practice to meet such a phenomenon; a good nurse, more particularly in midwifery practice, being so hard to get, especially in North Queensland. As a rule they are ignorant and clownish, and drunkards to boot.

Patient, being a strong healthy woman, recovered quickly, and insisted on getting up the fifth day. On the thirteenth day she went for a walk and was overtaken by a thunderstorm and received a great wetting. Three days later I was called in to see her. Found her in bed complaining of great pain in lower abdomen, with some vomiting, pulse increased in frequency, temperature 104°, had chills day before, bowels confined, vagina hot and swollen. Ordered vagina to be washed out three times a day with warm water and Condy's fluid; linseed meal poultices to be constantly applied over abdomen; warm hip baths at night, and warm water and castor oil to be injected into the rectum to allay the sickness; ordered an effervescing mixture of bicarb. soda and potash, with citric acid. On second day the pain in groin was so severe that I injected $\frac{1}{4}$ gr. morphine sulph. c. $\frac{1}{100}$ gr. atropine sulph. hypodermically, and continued hot poultices; diet light and nutritious.

This treatment was kept up for six days, when the pain in groin shifted, and on the eighth day it had disappeared, and patient was able to move to the sofa. By this time she has quite recovered, but this happy ending of such an extremely grave case is not the rule generally.

I am, etc.,

E. ST. GEORGE QUEELY,
Medical Officer, Palmer River District Hospital.
Maytown, Queensland, March 27, 1888.

A CASE OF UNUSUAL DISLOCATION.

(To the Editor of the A. M. Gazette.)

SIR,—A case of unusual dislocation recently occurred in my practice, viz., that of double dislocation of the hip joints, on the dorsum ilii. A young lady was driving with three companions in a buggy, and on going down a rather steep hill, the horse became restive, and the front buggy wheel, off side, collided with a fence post, while her right foot was forcibly depressing the break; this concussion probably produced the dislocation of the right joint; she then fell forwards, giving a half-turn towards the near side of the buggy, and was found between the front wheel and the body of the buggy near side; the dislocation of the left joint must have occurred during this rotation, the femur being forcibly abducted, and at the same time bearing the weight of the trunk and causing dislocation. The patient was placed under the influence of chloroform and the dislocations readily reduced by manipulation.

RICH. READ, M.D.

Singleton, N.S.W., April 23, 1888.

EUCALYPTUS OIL IN TYPHOID FEVER.

(To the Editor of the A. M. Gazette.)

Dear Sir,—Several months ago an interesting account was given in the *Gazette* of the value of oil of eucalyptus in typhoid fever. The beneficial results which Dr. Kesteven obtained were, according to his statistics, most remarkable.

After effects so good, it would be interesting to know whether any other practitioner has had similar results; it would be specially so if the Medical Society of Queensland, for instance, could give some information in reference to this matter.

The interest I take in getting information in regard to Australian drugs, as well as the general importance of the question, will be, I hope, sufficient reasons for my trespassing upon your valuable space.

I am, Sir, yours faithfully,

THOMAS DIXSON,

Lecturer upon Therapeutics, University
of Sydney.

April 27, 1888.

THE DONDERS' MEMORIAL FUND.

(To the Editor of the A. M. Gazette.)

SIR,—Will you kindly allow me to acknowledge in your journal the following subscriptions to the "Donders' Memorial Fund."

I am, Sir,

Your obedient Servant,

JAMES T. RUDALL, F.R.C.S.

Treasury Gardens, Melbourne.

Baron Sir F. von Mueller	...	...	£2	2	0
Dr. James Jackson	...	...	2	2	0
T. N. Fitzgerald, F.R.C.S.I.	...	...	2	2	0
Dr. M. J. Symons, Adelaide	...	...	1	1	0
A. S. Gray, M.R.C.S.	...	...	1	1	0
G. A. Syme, F.R.C.S.	...	...	1	1	0
J. W. Barrett, F.R.C.S.	...	...	1	1	0
W. Rudall, F.R.C.S.	...	...	2	2	0

REPORT ON TYPHOID FEVER IN THE DISTRICT OF LAGGAN, N.S.W.

THE following abstract of a report by the Deputy Medical Adviser to the Government (Dr. Ashburton Thompson) on an outbreak of typhoid fever in the rural district of Laggan, presents some points of interest.

Laggan is a hamlet which stands in a farming district about 28 miles from Goulburn, on the high road to Peelwood and Tuena. In February, 1887, a case of typhoid occurred in the family Jones, who lived in a three-roomed cottage a mile and a half from the village. There were nine members—the parents and seven children, aged from about 20 years downwards; and in the course of the next three months all were attacked, the father and three children dying. No other cases in the district are known to have preceded this series, nor did any occur after it except as mentioned below. The cottage was isolated; water was taken from a well 300 yards from it; and there was a

cess-pit 20 yards away, but not towards the well. The patient who was first attacked had not been out of the district. On October 7, the widow sold the farm and the farm implements at auction, removing thereafter to Goulburn, whither she took all the furniture and articles of domestic use. About October 26, the family Tracy was invaded. They lived on the Peelwood Road ten miles or more from Laggan, and still further from the Joneses; the household consisted of the parents, six children from 15 years old downwards, and a boy who had lived with them two or three years, aged 11. William Tracy, aged five, was the first patient; he had not been away from home except to a neighbouring school; no other cases of this disease were known to have occurred in the district since the convalescence of the last case among the Jones family about the end of April; and the only communication held between the Joneses and Tracy was by the latter attending the sale mentioned. But he was not attacked until four months afterwards, and three months after William. During ensuing months to the beginning of March, all the members of the household fell sick, and two of them died.

Here, then, are two cases of the kind often quoted in support of the theory which asserts that typhoid fever may arise *de novo*; but inquiry revealed circumstances which destroy their value for that purpose, as usually turns out to be the case when opportunity of sufficiently particular investigation is available. With regard to the first family, Dr. Ashburton Thompson found that the girl first attacked was not infected at her home. She had lived there all her life until shortly before her illness, when she was engaged by a neighbouring farmer to assist at harvest time. She lived at this farm five or six weeks, and then returned home ill. It is, therefore, to this place that the infection must be ascribed; but that does not account for its origin, and the more that no fever is known to have existed there either before or after the case referred to. Here the inquiry, necessarily made as rapidly as possible, and rather for the purpose of judging what measures were necessary to prevent further spread, than to solve an etiological problem, is defective; but it is mentioned that the farmer employed other hands at the same time among whom there were strangers, and from one of these either then beginning to suffer, or else convalescent from typhoid, it is possible that the first Jones case was infected, perhaps through the medium of a common cess-pit. That the disease should have spread from her to the rest of her highly susceptible family after her return, either through their own cess-pit or by some other of the well-known channels, was to be expected under the circumstances. As for the second family, it was found that they lived in a small cottage with dirty surroundings, on the high road; that they had lived there at all events several years; that there was no privy at all; and that they got their water from a small hole at the head of a creek which first showed a definite bed below the road on the side opposite to the cottage. This creek did not run except during rains; nevertheless the presence of the waterhole referred to close to its head, showed that it collected a considerable volume of subsoil water, the greater part of which must have been drawn from the land about the cottage on the other side of the road. This road is the highway to the important silver mines in the districts mentioned at first, and has been much travelled of late; and, as the hole is unprotected, the possibility that the water had become fouled by some wayfarer, either directly or by the deposit of infectious excreta on the neighbouring watershed, is too great to be passed over in favour of the pythogenic theory.

THE INTERCOLONIAL RABBIT COMMISSION.

THE Royal Commission representing the colonies of New South Wales, Victoria, South Australia, Queensland, New Zealand, and Tasmania, appointed to inquire into and report upon M. Pasteur's and other schemes for the destruction of rabbits in the Australasian Colonies, and consisting of Dr. H. N. MacLaurin, Dr. Wilkinson, and Mr. E. Quin, representing New South Wales; Professor Allen, Mr. Lascelles, and Mr. A. N. Pearson, Victoria; Dr. Stirling and Dr. Paterson, South Australia; Dr. Bancroft, Queensland; Mr. T. A. Tabart, Tasmania, and Mr. A. Dillon Bell, New Zealand, commenced its labours on April 16, when Dr. MacLaurin was elected President of the Commission. Afterwards, Professor Allen delivered a long address, in the course of which he dealt exhaustively and with great clearness upon the proposals made for the extermination of the rabbit pest by M. Pasteur and Dr. Ellis, detailing the several schemes propounded. He pointed out that the great question to be decided was as to the efficiency and safety of the proposed remedies, and to this end he thought that all the labours of the Commission should be devoted.

On the second day, April 17, the Commission resolved that the Government should be asked to set apart an island upon which experiments might be made with diseases that did not already exist in Australia; and that experiments with diseases already existing in the colonies might be carried on in an inland tract of country, in order to test their efficiency, safety, and practical utility. The opinion of the majority of the members of the Commission was that the scheme of M. Pasteur ought, in the first instance, to be applied to the rabbits on an island where little danger was to be apprehended to other forms of animal life. Should it be found that it is not injurious to stock, an opportunity will be given for testing its efficacy in the interior. Until M. Pasteur's scheme is demonstrated to be safe or injurious to animals generally, the other schemes are not to be tested in the interior of the colony. In the afternoon, Dr. Ellis, who has been carrying on a number of experiments in conjunction with Dr. Butcher on the Tintinnalloy Station, on the river Darling, was examined at length, and gave an exhaustive history of the disease, which, if communicated to rabbits, reduced the animals to a state of emaciation, and they generally died in from 15 to 20 days; it was also proved that only one rabbit in a thousand was not susceptible to the disease.

On April 18, some of the members visited Dr. Ellis's hutches at Double Bay for the purpose of witnessing some of the results of experiments which have been made, and also to hold *post mortem* examinations on some of the infected rabbits.

At a meeting held on April 23, it was decided that the Minister should be requested to send the metropolitan district surveyor with any person the Commission might appoint to examine Broughton Island (near Port Stephens), with a view to discover its adaptability or otherwise for the experiments desired to be made. The Commission then considered the offers made by Mr. E. Quin, of Teralla station, near Wilcannia, and Mr. Evan Evans, of Roto station, in the Hillston district, both of which gentlemen had liberally placed their holdings, free of cost, with the use of fencing, homestead, horses and servants at the disposal of the Commission. After mature deliberation it was decided to accept Mr. Quin's offer (subject to the approval of the Government), as the Teralla station was contiguous to the Tintinnalloy run, on which Drs. Ellis and Butcher had been conducting their experiments.

The three representatives of M. Pasteur—M. Loir, and Drs. Germont and Hinds—were then accorded an interview, the lastnamed acting as spokesman. Upon the application of Dr. Hinds, the Commission decided to allow M. Pasteur's representatives to cultivate the microbes introduced by them through inoculation with suitable animals, in order to keep them alive; such inoculation to be under the direct supervision of the Commission, or whom they might appoint. With regard to the fencing-in of areas for the conducting of experiments, it was resolved that the Lands Department be recommended to fence in small areas, within the larger area of 10,000 acres already mentioned, of from 50 acres to 100 acres, with certain fixed gauge and mesh wire. It was further settled that advertisements be inserted in the newspapers inviting information from persons who had been in a position to observe rabbits dying from disease, and also setting forth that the Commission desired to obtain, by purchase, fowls suffering from the effects of cholera, with a view to further experiments as to the efficiency of the systems proposed.

The Commission continued its sittings on April 24, when it was resolved that Dr. Katz, an expert in bacteriology, at present in the employ of the Linnean Society, be recommended to the Government for appointment as chief expert under the Commission. A schedule of experiments, brought up by a Sub-committee, was adopted as a general basis of directions to the chief expert. A series of experiments will be conducted at the laboratory of the Central Board of Health, and Dr. MacLaurin has been asked to prescribe the precautions to be observed during the progress of the experiments. The main experiments to be carried out will be divided into three series, of which the following is a summary:—First Series: To test the communicability of chicken cholera to rabbits and the possibility of spreading the disease from rabbit to rabbit, and to ascertain the readiness with which such communication could be procured, and the exact channel of the communication. Second Series: To ascertain whether the disease is transmissible from infected rabbits to other domestic animals—both mammals and birds. Third Series: To test whether the infecting power of the disease is weakened by repeated transmission from rabbit to rabbit.

The representatives of New South Wales, and Mr. Dillon Bell, of New Zealand, and Mr. Pearson, of Victoria, were appointed a Committee to watch the proposed experiments on behalf of the Commission, and it was arranged that progress reports should be furnished by the Committee to the Commission.

On April 25 the Commission adopted a motion to the effect that in order to save time in arriving at a definite conclusion, and in view of the fact that inland experiments can be conducted with such precautions as to render them as safe, or safer than experiments on an island, it be resolved that so soon as it shall be proved to the satisfaction of the Committee already appointed that the introduction of chicken cholera amongst rabbits would not do injury to the domestic animals mentioned in the proclamation of the colony offering a prize of £25,000, experiments be conducted with chicken cholera in an enclosure about 100 yards square, surrounded with wire netting of $\frac{1}{2}$ -in. mesh, and, if necessary, roofed over with the same material. The enclosure thus formed to be further isolated by an ordinary rabbit-proof wire fence erected around the enclosure at a distance of two chains from it.

The Commission met again on April 26, for the last time this session. An intimation was received from the Government appointing Dr. Katz as principal expert officer to the Commission. With regard to the application of the Commission to be allowed to take a house

and grounds near Sydney for experimental purposes, Rodd Island, near Balmain (Sydney) has been placed at the disposal of the Commission for the purpose.

Should the Commission receive the offer of the use of a rabbit-infested paddock within easy reach of Sydney, it would take advantage of the offer to commence experiments almost at once. The Commission also received applications from certain gentlemen who desired to carry out experiments on their own runs with poison, asking for permission to do so under proper precautions. The Commission replied that they saw no reason why this request should not be granted. The Commission were also of opinion that licenses to prosecute their inquiries into the Tintinallurgy disease might be granted to Drs. Butcher and Ellis, with safety to the public health.

The Commission transacted a large amount of routine business, and then adjourned until the 23rd May, when they will meet again at Adelaide. There they will investigate the nature of the disease known as rabbit scab, which Professor Watson, of the Adelaide University, has been propagating. They will then proceed via Silvertown to Tintinallurgy, where they will take evidence regarding the nature of the diseases which have been discovered there.

[Note.—Experiments have been made in the laboratory of the Board of Health for the purpose of testing the efficacy of M. Pasteur's scheme of rabbit destruction by the introduction of chicken cholera, but so far they have not proved successful; a number of rabbits, inoculated with the microbes sent out by M. Pasteur, were not affected by them in any way, though the disease ought, according to M. Pasteur, to have proved fatal within 24 hours. The representatives of M. Pasteur intend to revivify the microbes and to increase their virulence by cultivating them in a proper medium, and then to renew the experiments.]

WELCOME HOME BANQUET TO THE HON. C. K. MACKELLAR, M.B., M.L.C.

THE Hon. C. K. Mackellar, M.B., M.L.C., of Sydney, was entertained at dinner on Friday night, April 20, by his professional friends, for the purpose of welcoming him back to the colony on his return from Europe. The banquet was held at the rooms of the City Catering Company (late Gunsler's), in Pitt-street, where between 60 and 70 gentlemen sat down at 7 o'clock to admirably furnished tables. The chair was occupied by Dr. MacLaurin, Vice-chancellor of the University and President of the Board of Health; the guest sat on his right, and Dr. Milford on his left. The Vice-chairmen were the Hon. J. M. Creed, M.L.C., Professor Anderson Stuart, and Sir Alfred Roberts. Amongst those present we noticed Drs. P. Sydney Jones, F. Norton Manning, T. Chambers, Foreman, Knaggs, A. Watson Munro, Wright, Chisholm, W. W. J. O'Reilly, Ward, Hankins, M'Cormick, Goode, Bowker, Ashburton Thompson, Oram, Worrall, Crago, Jenkins, Fiaschi, Shewen, Graham, H. Sinclair, Twynam, Pockley, M'Culloch and Walker Smith; Dr. Bancroft, of Brisbane, and Dr. Stirling, of Adelaide, were among the visitors.

Apologies for absence were read from a number of gentlemen, among these being M. Loir, Dr. Hinds and Dr. Germont, representatives of M. Pasteur.

After the usual loyal toasts had been proposed and honored, the CHAIRMAN gave the toast of "Our Guest." He said:—"It is now my pleasant duty to propose to

you the toast of the evening, the health of our worthy and esteemed friend, the Hon. Dr. C. K. Mackellar. (Cheers.) I am sure that it requires very few words from me to commend such a toast to an audience of Sydney medical men. Dr. Mackellar is no stranger among us; he is not one whose life has been passed in obscurity, or whose good deeds have been done in a corner. For many years Dr. Mackellar has been prominent before the public, and he is well known, not only to us here present, but I may say to almost every member of this community for vigor of character, kindness of heart, and thorough devotion to his professional duties. (Applause.) A native of this colony, of ancient and honorable Scotch extraction, and the son of a distinguished medical man in Sydney of former days, Dr. Mackellar in early youth felt himself attracted, both by the character of his mind and by hereditary disposition, to the study of medicine. After conquering difficulties, which it is not now necessary to touch upon, but which bear honorable testimony to his determination to surmount all obstacles, Dr. Mackellar proceeded to the University of Glasgow, where he attended the medical classes, and after the usual course of study, marked by more than ordinary zeal and industry, in which he took advantage of the unusual opportunities for professional study at that time to be found in the capital of the west of Scotland, Dr. Mackellar obtained his degree in medicine with great honor and credit to himself, and with the esteem and affection of all his teachers. ("Hear, hear.") Shortly afterwards Dr. Mackellar returned to the country of his birth, which he intended also to make the country of his life and labors, and it was about that time, some 17 years ago, that I had the pleasure of making his acquaintance, which has gradually developed into one of the most warm and lasting friendships of my life. From that day his career is well known to us. We know how, from small beginnings, by hard work and indomitable perseverance, he steadily improved his position, till after a comparatively short time he found himself distinctly in the foremost ranks in the medical profession in Australia. (Applause.) Nor did he confine himself, even at this early period of his career, to the lucrative walks of private practice. He soon became attached to the Sydney Infirmary, where he served for several years as honorary surgeon. As I was at the time one of his colleagues, I can bear testimony to the thoroughness with which he discharged the duties of his position, and the uniform kindness and consideration which he showed to the sick poor who came under his care. From the beginning of his professional career Dr. Mackellar's mind had always a strong bent toward such measures as would seem to be beneficial to the public health. The advancement of sanitary science was a cause which he always had deeply at heart, and he was always on the look-out for any opportunity which might offer for advancing this noble purpose. In 1882 this opportunity came to him. After the serious outbreak of small-pox, which most of us remember, the Government determined to re-organise the medical service of the colony, which had previously been in a somewhat chaotic condition, and they most wisely decided that the best man to carry out their purpose was our friend Dr. Mackellar. (Cheers.) Of his services in the capacity of Chief Medical Officer of the Government it is scarcely necessary to speak. We all know them and their results, how conscientiously he performed his duties, and how excellent an administrator he showed himself to be. As is well known, he did not confine himself simply to the duties of an administrator. The subject of quarantine, which had been surrounded with numberless difficulties and doubts, he determined to elucidate thoroughly, so far as all events as these colonies are concerned. For this

purpose he obtained the assembling of an intercolonial sanitary conference, over which he presided, and the deliberations of which it is no secret were mainly guided by his influence. The report of that conference contained an admirable exposition of the objects and methods of quarantine, and if their recommendations as the federal quarantine had been adopted the Australian colonies would have been spared a great deal of subsequent trouble. ("Hear, hear.") In 1885, at the request of the Government of the day, Dr. Mackellar resigned his office, and became a member of the Legislative Council. Here he was the means of introducing a bill for the management of public health, which had been mainly prepared under his supervision. Owing to political reasons this bill did not pass, which was, I believe, a great misfortune for the colony. There can be little doubt that if this measure had become law a great deal of the disease from which we had suffered in this colony would have been prevented. ("Hear, hear.") For some time Dr. Mackellar served as the representative of the Government in the Upper House, and in this capacity, though somewhat foreign to his previous training, he secured the cordial esteem and respect of his colleagues in the Government and in the Legislative Council. Twelve months ago he left for Europe to enjoy a well-earned holiday, and now that he has returned to the scene of his former labors we have met this evening to give him a hearty welcome. (Applause.) I call upon you therefore, gentlemen, to join with me in doing honor to one who is equally estimable as a physician, as a public man, and as a warm private friend."

The toast was drunk with enthusiasm.

Dr. MACKELLAR, who on rising to respond was greeted with loud cheers, said:—"I am afraid that I shall utterly fail to find words to express my very keen appreciation of the honor which you have done me in inviting me to this magnificent banquet this evening. I am not usually of a very retiring disposition, but I am on the present occasion overwhelmed by a sense of my own unworthiness, and of the kindness of heart which has stimulated my professional brethren to do me this honor. There is an old saying, which has been so often repeated that many persons have felt half inclined to believe it to be true, to the effect that "doctors differ." Now, if anything was necessary to demonstrate the fact that they can sometimes agree, it would be found in the circumstance that about 60 of my professional brethren have assembled here to-night to do me what I am afraid is but a little-merited honor. I have to thank you, Mr. Chairman, for the kindly way in which you have proposed the toast of my health, and you, gentlemen, for the enthusiastic manner in which you have received it. The warmth of heart which dictated to my friend MacLaurin the kindly and sympathetic sentiments to which he has given utterance is in strict keeping with what I have invariably experienced at his hands during what has been practically my whole professional life. He has told you of difficulties which I have had to encounter, but he has not told you how much of the success which has attended my efforts to encounter them has been due to his friendly counsel; nor has he mentioned the deep obligations under which I labour for the very hearty and disinterested co-operation which I received from my medical brethren whilst it was my lot to administer the public health laws of the colony. He has been good enough in reviewing what after all has been an exceedingly commonplace, although I trust not altogether useless career, to make special allusion to the Public Health Department, for the organisation of which I am supposed to be responsible. ("Hear, hear.") However, you must know, gentlemen, that a very large part of

the work of its organisation was the result of the labors of my friend Sir Alfred Roberts, who, moreover, had indeed by far the largest share in quelling the first smallpox epidemic in this city, and I can assure you it was a most onerous task. I took charge of the department which had in a great measure been formed by that gentleman, and if any credit is due to me in the matter, it is rather from the circumstance that I doggedly and persistently followed his lines than that I formulated any original scheme of my own. The Public Health Bill—I am sorry that I cannot call it the Public Health Act—"hear, hear")—with which my name has been so intimately associated, was also by no means the result of my sole labors. Mr. Bernhard Wise, the late Attorney-General, and my friend and colleague Dr. Ashburton Thompson, principally the latter, had a large share in its formulation; and perhaps the most important duty that I performed towards it was that I induced the Government of the day, that of Sir Alexander Stuart, to believe in the necessity for its introduction. I would that I could similarly impress Sir Henry Parkes. ("Hear, hear.") After these disclaimers I think I can fairly, on behalf of the Board of Health, take credit for having exercised with firmness and discretion the very limited powers assigned to it by the Act under which it was created. (Applause.) The Board, in fact, may claim to be classed among the vertebrates—it has a good backbone. It has been customary in some quarters to stigmatise our system of dealing with infectious diseases in Australia as clumsy and antiquated, but when I tell you that smallpox has been brought to this city between 50 and 60 times, not to speak of the times it has been introduced into the sister colonies, and that, nevertheless, it has not yet become epidemic, notwithstanding the fact that in New South Wales we are practically an unvaccinated community—when I tell you this, I think you will be prepared to hold with me that we should not adopt any other system unless its working has demonstrated that it has produced a similar immunity in other countries—(cheers)—and so far as I know, no other system has done so. During my recent visit to Europe I met many distinguished sanitarians, and they were almost unanimous in deploring that their laws did not provide for similar compulsory segregations of those sick with infectious disease. One celebrated sanitarian, Professor Gairdner, himself the originator of a very complete sanitary system, expressed his admiration for this one law of King Demos, being of opinion that only in a democratic country would it be possible to bring the people to carry out so stringent a law without friction. (Cheers.) Now, one word before I sit down. A good many of you, gentlemen, are aware that the reason for my recent visit to Europe was not because I either required or desired a holiday but because of the ill-health of one of the members of my family, who had been suffering for some time from an obscure affection of the hearing, and had been at various times under the care of several of my professional friends, namely, Dr. Oram, Dr. Jones, Dr. Knaggs and Dr. Schwarzbach, and I am under very deep obligations to all those gentlemen for their skilful attention and advice; and although this may not be quite the place to allude to such a matter, yet as I have not yet had an opportunity of telling them—and three of them are here present—I feel impelled to do so, and I think it probable that they will be interested to learn that their opinions, both as to the diagnosis of what is acknowledged to be a very obscure case, as well as to treatment and prognosis, have been confirmed by the most eminent aurists in England, Scotland and Germany. ("Hear, hear.") I have to thank you again, gentlemen, for the

very cordial manner in which you have received the toast, and I assure you that my efforts in the future will be directed, as they have been in the past, to advance the honor and dignity of the profession to which I have the privilege to belong." (Loud Cheers.)

Professor ANDERSON STUART gave the toast of "*Floreat Res Medica*," and in doing so spoke hopefully of an advance in the science of medicine to be made in the future, and the probability of much greater certainty being attained in the treatment of disease.

Dr. P. SYDNEY JONES responded. He dwelt briefly on the progress in medicine during the past half-century, referring to the most important of the discoveries made, whereby the human death-rate had been so markedly lessened.

Sir ALFRED ROBERTS proposed "Our Illustrious Visitors," and Dr. BANCROFT, of Brisbane, and Dr. STIRLING, of Adelaide, responded.

The toasts of "The Ladies," by Dr. FAITHFULL, and "The Chairman," by the Hon. J. M. CREED concluded the list.

VITAL STATISTICS OF SOUTH AUSTRALIA FOR 1887.

THE estimated population of South Australia, including the Northern Territory, on the 31st December, 1887, was 319,703, including 6,346 aborigines. The registered births during the year numbered 10,831, or at the rate of 35·07 to every 1,000 persons living, this being the lowest recorded in any of the preceding ten years. The births of males numbered 5,666; of females, 5,165. The proportion of male births to 100 female births is 109·7. This proportion is unusually large, and has been exceeded but once in the ten preceding years. The illegitimate births numbered 270; the proportion of illegitimate births to 1,000 persons living was 87; to 1,000 unmarried women, at ages between 15 and 45 years, 87; to 100 of the whole number of births registered in the year, 2·49. The illegitimate births in Adelaide and suburbs alone were 198, an increase of 15 above the number of last year; the rate to 1,000 of population being 1·78; to 1,000 of total births, 51.

The registered deaths numbered 3,944. This is the lowest number of deaths recorded since 1880, when they were 3,912. The death-rate per 1,000 of the population is 12·77; and with the exception of that of 1885, which was 12·48, is the lowest in the ten years from 1878.

The deaths in the city of Adelaide were 848, closely approximating to those of 1886, which were 856. The annual death-rate per 1,000 of the population was 19·75. The deaths in the city of Adelaide, exclusive of deaths in public institutions of persons not usually resident in the city, numbered 710; and the death-rate per 1,000 of the population was 16·64.

Of the whole number of deaths in the province the males numbered 2,240; the females, 1,704—the former exceeding the latter by 536. To every 100 deaths of females, the deaths of males were 131·4. In 1886 the excess of the deaths of males was 464; and the proportion to 100 deaths of females 124·6. The death-rate of males to 1,000 of the male population was 14·1, in the place of 14·4 in the last year; of females to 1,000 of the female population 11·3 in the place of 12·4. The proportion of deaths at different ages to 1,000 deaths at all ages is as follows:—Under 1 year, 305; from 1 to 5 years, 103; from 5 to 20 years, 78; from 20 to 40 years, 171; from 40 to 60 years, 141; from 60 to 80 years, 161; 80 years and upwards, 41.

Six hundred and sixty-four deaths were due to symptomatic diseases, and of these, *measles* was fatal in two cases and *scarlatina* in seven. It was ascertained that, although these diseases have occurred in different parts of the colony, they have been prevented assuming the character of an epidemic. During the last three years the deaths from measles have been only eleven, and from scarlatina only twenty-four. *Whooping cough* has been fatal in thirty cases against ninety-three in 1886. The deaths from *diphtheria* were fifty-nine, being a diminution of thirty. The deaths from *enteric fever* were 143, being an increase of sixty on those in 1886. The deaths from *simple cholera* and *diarrhoeal diseases* were 361, against 528 in 1886. Of this number 262 were deaths of infants under one year old.

Of fifty-four deaths from dietetic diseases, thirty-nine are reported as having occurred in infants under one year old from starvation (want of breast milk). The other fifteen deaths were caused by drunkenness. It must be remembered that the greater number of deaths from diarrhoea in infants rightly belong to this class; but the certificates of causes of death furnished to the office do not supply data for classification.

Of the causes of death, *cancer* ranks tenth in the order of fatality. The deaths from this disease were 110, against 104 in 1886. Of these fifty-nine were of males and fifty-one of females. The youngest male was under twenty-five years old, and the oldest was beyond eighty. The youngest female was eight years old, and the oldest beyond eighty. One death in the proportion of every $8\frac{1}{2}$ of the total deaths in the colony was caused by tubercle. If the modern belief that tuberculosis is caused by a bacillus which is communicable under certain conditions, the statistics show that this microbe is the most formidable which has to be contended with in Australia. The total number of deaths from tubercular diseases was 468, viz.:—phthisis 353 (males 199, females 154) or 1.14 per 1,000 of population; tubercular meningitis 63; tabes mesenterica 37, other forms 15. Of the total deaths from phthisis, 140, or 39.7 per cent., were of persons born in the province; 132, or 37.3 per cent., of persons not born in the province; and 81, or 23 per cent., of persons (deceased in hospitals, asylums), whose length of residence in the province could not be obtained. The number of deaths of persons was, after a residence of 5 years, 42; 10 years, 24; 20 years, 23; 30 years, 32; 40 years, 11; not stated, 81.

The deaths from developmental diseases were 430, against 407 in 1886. Of this number 104 were due to premature birth, 32 to structural defects, and 304 to old age.

One thousand six hundred and twenty-five deaths were registered under local diseases. Of these 423 occurred in children under one year old; 126 of these children died from convulsions, 100 from diseases of the respiratory organs, and 75 from dentition. The number of deaths from insanity were 47, against 35 in 1886, and against 114, which was the average of the preceding ten years. The deaths due to violence were 186 of males, and 43 of females; 22 men and 7 women committed suicide. There were 198 deaths from accident and 2 from homicide.

Medical Books at PUBLISHED Prices.

MR. BRUCK, Medical Bookseller in Sydney, begs to inform the profession that he is selling all medical books at PUBLISHED prices. A list of some of the books in stock, with published prices attached, will be found in this issue. Mr. Bruck has just received an assortment of the latest works by the R.M.S. "BRITANNIA."

THE MONTH.

NEW SOUTH WALES.

THE buildings known as the Protestant Orphan School, Parramatta, have been set apart as an Hospital for the Insane, to be called a Branch of the Hospital for the Insane at Parramatta.

DR. MACLAURIN, Dr. Manning, Dr. O'Connor, and the Comptroller-General of Prisons, have been appointed to inquire into the diet and scale of allowances to prisoners who are confined in the gaols of the colony.

ON April 23, Lord Carrington took formal possession of the Grasmere Estate, Camden, as a hospital for convalescents and incurables, from Mr. W. H. Paling, who handed over the title deeds. The estate consists of some 507 acres, but about 80 acres are reserved during Mr. Paling's life and that of his two stepsons. The Governor appointed three trustees (Mr. Dalley, P.C., the Hon. Dr. Benwick, M.L.C., and Col. Goodlet), also the first committee, amongst whom we notice the names of Sir Alfred Roberts and Dr. MacLaurin.

ONLY 3,000 persons availed themselves last year of the facilities offered for free vaccination, and the health authorities strongly advocate the introduction of compulsory vaccination, pointing out that until this is done it is impossible to relax the present stringent precautions against small-pox.

A CHINAMAN, residing in a lane off Belmore Park, South Sydney, was, on April 20, found to be suffering from leprosy; he was at once removed to Little Bay Hospital, where accommodation was found for him in the leper house. It may be mentioned that there are six Chinese patients in the hospital suffering from the same disease.

THE following practitioners have been appointed magistrates of the colony, viz.:—Drs. G. Cuscaden, Urana; E. H. Morgan, Mt. Victoria; B. T. Russell, Merriwa, and John Service, Newtown.

IN the Central Criminal Court, Sydney, on May 3, Evan Thomas, a chemist, carrying on business in Botany-road, Waterloo, was charged with the manslaughter of an infant, by administering to it an excessive amount of opium. After somewhat prolonged deliberation, the jury decided to give the accused the benefit of the doubt. They found him not guilty, and the accused then left the court.

IT is the intention of the health authorities to institute proceedings against Dr. Watkins, of Manly, for having neglected to report a case of small-pox which developed in the family of Mr. Lakeman, M.P. By omitting to do so he has rendered himself liable to a penalty of not less than £10 or more than £50.

WE regret to learn that Dr. F. H. Quaife, of Queen-street, Woollahra (Sydney), has been suffering from typhoid fever during the last few weeks.

DR. PETER BANCROFT, of the Prince Alfred Hospital, Sydney, has been awarded a gold medal as the result of the examination for the degree of M.B. lately held at the Sydney University.

DR. J. MARTIN BROWNE, late of the Glebe (Sydney), has removed to Minmi, in a coal-mining district, 89 miles N. of Sydney.

ON April 19, Dr. Edw. Chisholm and his wife and daughter were being driven from their residence in Ashfield to Sydney in a brougham drawn by two spirited horses. When nearing Petersham the horses bolted, and travelled at a terrific speed through Camper-

down, where the vehicle collided with a telegraph post, and a complete wreck was the result. Fortunately the occupants, who were thrown out, were not seriously injured.

DR. C. DRINKWATER, a new arrival, has settled at Broken Hill.

DR. S. A. LONG has succeeded to the practice of Dr. E. L. Piercy at Wagga Wagga.

DR. ALEXANDER McCORMICK, M.D., Edin., has been granted the M.D. (*a.s.g.*) degree of the University of Sydney.

DR. H. N. MACLAURIN has been re-elected Vice-Chancellor of the University of Sydney for the ensuing twelve months.

DR. H. N. MACLAURIN was elected President of the Intercolonial Rabbit Commission at its first meeting held in Sydney, on April 16.

DR. J. J. G. MURRAY, late of Maryborough (Qu.), has commenced practice at Parkes, in a mining and agricultural district, 295 miles W. of Sydney.

DR. W. J. MORTON has succeeded to the practice of Dr. L. Fitzpatrick at Queanbeyan.

DR. G. J. L. O'NEILL, of Sydney, and Dr. E. T. Thring, of Petersham, have been elected members of the Royal Society of N. S. Wales.

DR. R. FAIRFAX READING has commenced practice at 189 Elizabeth-street, Hyde Park, Sydney.

DR. T. B. WALLEY, late of Narrabri, has returned to the colony after a sojourn of twelve months in the old country.

DR. R. A. WILSON has succeeded to the practice of Dr. L. G. Davidson, at Balmain, near Sydney.

NEW ZEALAND.

AT the Supreme Court, Dunedin, on April 12, Dr. T. J. Rennie, who is connected with a Canadian lady doctor, was acquitted of the charge of indecent assault on a girl of 17 years of age, referred to in our last issue.

DR. W. BROWN, of Dunedin, who for some years past has taken a very deep and active interest in educational matters, was on April 19 unanimously re-elected Chairman of the Otago Education Board.

DR. C. A. EDWARDS, a new arrival, has commenced practice at Westport, in a coal mining district, 145 miles S.W. of Nelson.

QUEENSLAND.

A CHINESE leper has been discovered at Tabletop, near Croydon. Dr. O'Doherty, Government Medical Officer, who examined him, pronounced the case to be undoubted leprosy, and ordered the isolation of the patient. The leper has since been removed to Cooktown.

A SURGEON is required for the hospital at Muttaborra, 850 miles N.W. of Brisbane; salary, £350 per annum, with right of private practice. Applications must be in the hands of the Secretary, Mr. J. F. Hollis, not later than June 11.

DR. J. L. CUPPAIDGE has been appointed a licensing magistrate for the district of Roma.

DR. T. M. HARDING, formerly of Balmain, near Sydney, has settled at Thargomindah, on the Bulloo River, 670 miles W. of Brisbane.

DR. J. A. HAYDEN, formerly of Dimboola (Vic.), has settled at Muttaborra, the centre of a large pastoral district, 850 miles N.W. of Brisbane.

DR. JAMES HILL, of Brisbane, has been appointed Official Visitor to the Lunatic Asylum, Goodna, and the Reception-house, Brisbane, in the room of Dr. Rendle, resigned.

DR. W. M. KING, late of Teneriffe (Brisbane), has removed to Port Douglas, on the shores of Trinity Bay, 1,000 miles N.W. of Brisbane.

SOUTH AUSTRALIA.

A BANQUET was tendered to Dr. J. Taylor Parkinson in the Institute Hall, Crystal Brook, on Tuesday night, April 10, on the eve of his departure for Europe for twelve months. Between fifty and sixty gentlemen were present. Mr. J. G. Young presided, and Mr. P. H. Claridge, J.P., occupied the vice-chair. After the usual toasts had been honoured, including the health of Dr. A. F. Smith, late of Perth, W.A., who takes Dr. Parkinson's practice during his absence, the assembly joined hands and sang, with much feeling, "Auld Lang Syne."

DR. S. J. MAGABRY, of Adelaide, has been elected a member of the Legislative Council for the Central District.

DR. W. MARKHAM, of Port Augusta, returned from England to South Australia by the steamer "Port Jackson" on April 13, after an absence of twelve months.

DR. R. S. ROGERS, a new arrival, has settled at Port Wakefield, on the shores of St. Vincent Gulf, 82 miles N. of Adelaide.

DR. C. H. STOW, of Palmerston, has been appointed Assistant Health Officer at Port Darwin, Northern Territory.

DR. H. SWIFT has commenced practice at West Terrace, Adelaide.

DR. P. M. WOOD, of Palmerston, the Government Medical Officer of the Northern Territory, returned to South Australia from England by the R.M. str. "Oceana." After an attack of fever some months ago he obtained leave of absence, and went to England for the sake of a sea voyage, remaining there only seven weeks.

VICTORIA.

THE Royal Commission appointed to inquire into the sanitary condition of Melbourne and suburbs took evidence on April 19, for the first time, Professor Allen presiding. Mr. Crawford Barlow, C.E., of London, gave an outline of a scheme for the drainage of Melbourne, recommending the adoption of the water-carriage system.

ON April 30, the Governor presented the certificates awarded by the St. John Ambulance Association to the pupils for proficiency in dressing wounds and attending the injured, &c. The gathering took place in the Melbourne Town Hall, and the pupils from the several centres gave illustrations of their skill in bandaging and dressing wounds.

DR. H. M. O'HARA, late of Brighton (Melbourne), who has just left for Europe, has been requested to act as accredited representative of the Hon. Medical Staff of the Alfred Hospital, to scientific bodies to be visited during his travels.

SCARLET Fever has made its appearance at Ballarat.

A FEVER ward for contagious diseases is to be erected at Belfast, at the joint expense of the shire councils of Port Fairy and Minhamite, and the borough councils of Belfast and Koroit.

ONE thousand and seventy-two cases of typhoid were reported to the Central Board of Health, Melbourne, from December 13 to April 12. Of these 235 proved fatal. 187 cases of diphtheria were reported between the 1st of December and the 12th April. Of these 65 proved fatal.

DIPHTHERIA in a most virulent form broke out amongst the scholars of the Dandenong State Schools, about the middle of last month; three deaths occurred within a few days.

THE following gentlemen have been elected Resident Medical Officers of the Melbourne Hospital for the ensuing twelve months, viz.: Messrs. Lionel Francis Praagst, Richard Rawdon Stawell, John H. Evans, Frank Smith Crowther, and Conway Montgomery Macknight.

THREE medical members of the Dental Board of Victoria—Mr. T. M. Girdlestone (president), Mr. J. P. Ryan, and Dr. Rowan—recently resigned, and their places have been filled by the appointment of Mr. Chas. Ross, Dr. Springthorpe, and Dr. Turner.

DR. ROTHWELL ADAM, having resigned his position of Honorary Physician attending in-patients at the Alfred Hospital, Melbourne, has been presented with an address by the Directors of the institution.

DR. W. ARMSTRONG has resigned the position of Medical Superintendent of the Hospital for the Insane at Ararat.

DR. J. B. BACKHOUSE, formerly Resident Medical Officer at the Prince Alfred Hospital, has succeeded to the practice of Dr. H. M. O'Hara, at Brighton, who has gone home by the R.M.S. "Oceana."

DR. W. R. BOYD, Resident Surgeon of the Melbourne Hospital, has been presented with a case of surgical instruments by the third-year students at the Melbourne Medical School, for the great courtesy and attention which he had shown to them during the past year.

DR. P. D. BRAY, late Acting Medical Officer at the Sydney Hospital, has commenced practice at Tintalra, on the Murray River, 276 miles N.E. of Melbourne.

DR. J. H. ECOLES has removed from Armadale to High-street, Malvern.

DR. GEO. HODGSON, of 244 Church-street, Richmond, has succeeded to the practice of Dr. Warren, at Richmond.

DR. R. F. HUDSON, of Ballarat, has been appointed a member of the Dental Board of Victoria.

DR. W. J. A. MOSS has commenced practice at 53 High-street, Prahran, near Melbourne.

DR. HY. MAUDSLEY, of Spring-street, Melbourne, has been appointed Honorary Pathologist to the Alfred Hospital, in the place of Dr. Springthorpe, resigned. The only other candidate for the position was Dr. A. S. Joske, late Resident Medical Officer of the Institution.

DR. G. MORE REID, President of the Castlemaine Gun Club, was entertained at a banquet by the members of the club at the Hermitage Vineyard, Barker's Creek, on April 25. During the evening Dr. Reid was presented with a handsome, artistically illuminated address.

DR. W. STUART, late of Minmi (N.S.W.), has commenced practice at Brighton, near Melbourne.

DR. M. BARCLAY THOMSON, of South Yarra, has been elected Honorary Physician to the Alfred Hospital, in the place of Dr. Rothwell Adam, resigned. There were nine applicants for the vacant position.

DR. J. D. TWEEDDALE, of Fitzroy (Melbourne), has been appointed Acting Health Officer for the Port of Port Phillip, and Superintendent of the Quarantine Station, Point Nepean, during the absence on leave of Dr. J. H. Browning.

DR. R. WALLACE has commenced practice as a homoeopathic physician at 8 Greville-street, Prahran, a suburban city of Melbourne.

UNIVERSITY INTELLIGENCE.

THE annual commencement of the University of Melbourne took place on Saturday, April 7, in the Wilson Hall, and the proceedings were witnessed by a large assemblage. The Chancellor (Dr. Brownless) presided, and conferred the following medical degrees:—

Bachelor of Surgery.—William Andrews, Joseph Francis Bartley, William Joshua Bird, John Henry Carney, Joseph Cookson, Walter Joseph Craig, Frank Smith Crowther, John Herbert Evans, Godfrey Howitt, Thomas Edwin Ick, Frederick David Jermyn, Conway Montgomery Macknight, Joseph John Miller, William Joseph Alleine Moss, Lionel Francis Praagst, Richard Rawdon Stawell, Charles Standford Sutton.

Master of Surgery.—James William Barrett, George Adlington Syme.

Bachelor of Medicine.—Godfrey Howitt.

Doctor of Medicine.—Eugene Wilton Anderson, William Christian Daish, Arthur Augustus Fletcher, George Thomas Howard, Sylvanus James Magarey (*in absentia*). *Ad Eundem.*—Harvey Eustace Astles, St. Andrew's; David Grant, Edinburgh; Louis Henry, Würzburg; John Nicholson, Edinburgh.

THE thirty-seventh annual commemoration of the Sydney University took place at the Great Hall on Saturday, April 14. The Chancellor (Sir William Manning) presided, and conferred the following medical degrees:—

Bachelor of Medicine and Master of Surgery.—Peter Bancroft, first class honors and gold medal; Alfred Edward Perkins, M.A., first class honors; William George Armstrong, B.A., second class honors; Arthur G. Henry, second class honors; Leslie Gordon Davidson; David Dunlop Rutledge, M.A.

Doctor of Medicine (ad eundem gradum.)—Alexander M'Cormick, M.D., Edinburgh; Ralph Worrall, M.D., Queen's University, Ireland.

Professor Anderson Stuart, Dean of the Faculty of Medicine, in presenting Mr. Bancroft for the degree of Ch.M. (the M.B. degree having been previously conferred), said that Mr. Bancroft was the first man who took a medical degree after having received an education solely in our own University. (Loud cheers.) He thought he ought in justice to add that Mr. Bancroft was not only the best man of the year, but was absolutely a splendid man. (Cheers.) He had obtained first class honors and the gold medal; he had passed exceedingly high, and his conduct had been most exemplary. (Loud cheers.)

At a meeting of the Senate of the University of Sydney, held on April 9, a letter was received from Mr. Cecil Purser, Honorary Secretary of the Sydney University Medical Society, urging upon the Senate "the necessity that exists for the more regular attendance, both as to day and hour, of the Honorary Medical Officers of the Prince Alfred Hospital; and

also of the necessity for the Honorary Medical Officers giving more bedside clinical instruction than they do at present." After considerable discussion, in the course of which objection was taken by the Chancellor to: any recognition by the Senate of a "society" amongst under-graduates which had received no authorisation from it and was not regulated by any by-laws of the University, as in the higher case of convocation, Mr. Justice Windeyer moved that the letter be sent to the Board of Directors of the Prince Alfred Hospital for its information. Mr. Barton moved, as an amendment—"That Mr. Purser be informed that the Senate will consider the application if made afresh under the signatures of the students who complain." The amendment, upon being put to the meeting, was negatived, and the original motion was carried.

THE University Senate has decided to recognise the Sydney University Medical Society by allowing it to retain the word "University" in connection with its name.

At a meeting of the Senate of the Sydney University, held on April 23, the following motion, proposed by Professor Stuart, and seconded by Dr. Sydney Jones, was agreed to:—"That the Senate, having considered the recommendations of the Medical Board of the Prince Alfred Hospital, that the Senate should appoint a Lecturer in Ophthalmic Medicine and Surgery, is willing to make such an appointment if the Board of Directors will place a sufficient number of beds under the charge of the officer appointed, to afford him the means of giving proper illustrations of his lectures."

HOSPITAL INTELLIGENCE.

At a recent meeting of the Committee of Management of the Alfred Hospital, Melbourne, the question of possible overcharging by members of the medical staff for operations upon patients in the paying wards was brought forward by Mr. Dickson. The following resolution was passed:—"That all operations not named in 'the scale of fees for operations,' shall be charged such fee as may be determined by the Hon. Medical Staff." The resolution to be embodied in the rules of the hospital.

A SPECIAL meeting of the Board of Directors of the Sydney Hospital was held on April 23, to take into consideration a letter sent to the Directors by Dr. MacLaurin, who urged that immediate steps should be taken to provide extra accommodation, particularly for females, for whom there were at present no vacant beds available in either of the Sydney hospitals. The subject of the letter having been discussed, it was resolved, on the motion of Dr. C. M'Kay, seconded by Mr. F. Senior, that a letter be sent to the Board of Directors of the Prince Alfred Hospital, asking them to appoint a meeting with the Board of the Sydney Hospital, with a view to consultation, and making a joint representation on the subject to the Colonial Secretary.

It is proposed to appoint an additional Honorary Physician, an additional Honorary Surgeon, and an additional Honorary Assistant Physician to the Prince Alfred Hospital, Sydney.

It is proposed to establish a cottage hospital at Wallsend, near Newcastle (N.S.W.). Plans and estimates are being prepared, and a public meeting for the furtherance of that object will be held early next month.

FROM a report of the Medical Officer of the Broken Hill (N.S.W.) Hospital, dated March 30, we learn that since the institution was opened, on May 21, 1887, ninety-four patients have been admitted, and of these 69 were discharged cured, 9 died, and 16 remained under treatment.

OBITUARY.

WILLIAM HENRY CAMPBELL.

It is our painful duty to have to announce the death of Mr. W. H. Campbell, M.R.C.S. Eng., 1838, L.S.A. Lond., 1840, the oldest medical practitioner in Melbourne, who died suddenly at his residence, Hotham-street, East Melbourne, on April 21, at the age of 73. The deceased gentleman had been suffering from heart disease for some years, so that his death, although very sudden, was not a surprise. Mr. Campbell arrived in Victoria in 1841, and was one of the earliest members of the medical staff of the Melbourne Hospital. He also sat for a time as a member of the City Council. After the discovery of gold, Mr. Campbell was appointed as the first District Coroner, which position, however, he soon resigned. The deceased gentleman was an Official Visitor of the Lunatic Asylums, Hon. Medical Officer of the Immigrants' Aid Society, and a Justice of the Peace. He married Miss Grylls, daughter of the first Episcopalian clergyman of the colony, and leaves two sons and four daughters. He was greatly respected and esteemed for his genial and kindly disposition, not only by his brother practitioners, but by all classes of the community.

The large-hearted and sympathetic nature of the deceased gentleman was manifested by the annual appeal which he made to the community to contribute a store of tobacco in order that the aged inmates of the Benevolent Asylum and the Immigrants' Home might enjoy their Christmas, and the appeal was never made in vain.

Mr. Campbell was an early riser, and he was moving in the house on the morning of the above date about 7 o'clock, when he dropped to the ground without any warning. Dr. Rothwell Adam was soon in attendance, but he found that life was extinct.

The attendance at the funeral, which took place on April 23, was very large and representative, and afforded a striking proof of the respect and esteem with which the deceased gentleman had been held by his fellow-citizens during his long career. Amongst the pall-bearers were Dr. Brownless, Dr. F. T. West Ford, Dr. John Williams, and Dr. W. G. Howitt.

WILLIAM GREGORY.

DR. WILLIAM GREGORY, L. et L. Mid. R.C.S. et R.C.P. Edin., 1869; M.B., 1873; M.D., 1881, Aberd.; F.R.C.S. Edin., 1881, J.P., Health Officer of the Swan-hill Shire and Public Vaccinator for the Kerang district, expired at his residence at Kerang (Vic.), on May 3, from gastritis. The deceased arrived in Queensland in June, 1878, and settled at Rockhampton, where he held the appointment of Honorary Medical Officer to the Port Curtis and Leichhardt District Hospital. About six years ago he left for Victoria, and has practised at Kerang ever since.

FRANCIS ARTHUR PATRICK KNIPE.

WE regret to have to record the death of Mr. F. A. P. Knipe, M.R.C.S. Eng., 1880, who died at Grenfell, N. S. Wales, after a lingering illness, on April 21, at the early age of 32 years. The deceased gentleman practised formerly at Malvern, England, and came to

the colonies early in 1886, when he commenced practice at Grenfell; a few months ago he suffered an attack of acute rheumatism, followed by dropsy, from which he never recovered. He was highly respected by all who knew him for his professional abilities and gentlemanly bearing.

WILLIAM LANE MARLEY.

WILLIAM LANE MARLEY, M.R.C.S. Eng., 1871, died at Port Douglas, Queensland, on March 22, aged 54. The deceased gentleman was a Justice of the Peace, and Medical Officer of the Port Douglas Hospital; formerly, he practised for many years at Stanthorpe, near the N. S. Wales border.

ROBERT PARK.

MR. ROBERT PARK, L.F.P.S. Glas., 1832, a Justice of the Peace, and very old resident of Gresford (N. S. Wales), died at his residence, Lewinsbrook, on April 14, after a lingering illness. For many years he occupied the position of Warden in the district council, and was otherwise closely connected with the interests of the Paterson and Gresford districts.

MEDICO-PARLIAMENTARY.

PARLIAMENT OF NEW SOUTH WALES.

On April 24, in the Legislative Assembly, Dr. Cortis moved that the order of the day in reference to the Registered Medical Practitioners Bill (No. 2), which lapsed by reason of the House being counted out on Tuesday the 6th March last, be restored to the paper at the point at which it was interrupted, and stand an order of the day for Tuesday, May 1. The motion was opposed by Mr. Melville, but eventually, upon Dr. Cortis promising that he would abandon that portion of it dealing with the registration of deaths, it was agreed to.

In the Legislative Council, on April 11, when the order of the day was called for the resumption of the debate on the second reading of the "Registration of Births, Marriages, and Deaths Bill," an objection was taken that it was out of order, inasmuch as it directed an appropriation out of the public revenue. The President ruled that the objection was fatal, and the Bill was withdrawn.

In the Legislative Assembly, on May 8, Dr. W. C. Wilkinson moved—"1. That steps should be taken to introduce a system of compulsory vaccination. 2. That an institution should be established from which vaccine taken directly from the calf could be obtained. 3. That the foregoing resolutions be communicated by address to his Excellency the Governor."

In the Legislative Assembly, on April 24, it was agreed, on the motion of Mr. Garrard, that a return be laid on the table of the House, showing:—"1. The number of deaths that have taken place, when the person has been under the influence of chloroform, during the years 1885, 1886, and 1887. 2. The date and number of inquests on persons who died while under chloroform during the same years. 3. The name of coroner or magistrate who held the inquests. 4. Nature of verdict in each case. 5. Locality of deaths. 6. Name of places where inquests were held. 7. Name of each deceased. 8. Name of the doctor or doctors present when the chloroform was administered."

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Prangley, Thomas, L.S.A. Lond., 1862; M.R.C.S. Eng., 1861.
Murray, John James Goodlatte, L.R.C.P. Edin., 1878; L.A.H. Dub., 1883; L.R.C.S. Edin., 1878.
Speer, Hugh Johnstone, M.D. Harvard Univ., U.S.A., 1874.
Bancroft, Peter, M.B. Univ. Sydney, 1888.
Nickson, Wilfred John Robert, M.B. & Ch. B. Univ. Dub., 1886.
Thompson, Charles Emilius, M.R.C.S. Eng., 1880; L.S.A. Lond., 1879.
Rosa, W. Chisholm, M.B. & Ch. B. Univ. Melb., 1886.
Jones, Walter William Stockton, L. & L. Mid. K.Q.C.P. Irel., 1881; L.R.C.S. Irel., 1881.

NEW ZEALAND.

Edwards, Charles Augustus, L. & L. Mid. R.C.P. & R.C.S. Edin.; L.S.A. Lond.

QUEENSLAND.

Hayden, James Augustus, M.R.C.S. Eng. & L.S.A. Lond., 1866.

TASMANIA.

Doyle, Charles William, M.B. & Ch. M. Aberd., 1876.

VICTORIA.

Stutt, Albert Edward, M.B., M.D. & Ch.M. Univ. of Trin. Coll., Toronto, Canada, 1891; L.R.C.P. Edin., 1881.
Wallace, Richard, L. & L. Mid. R.C.P. Edin., 1864; L.F.P.S. Glas., 1864.
Stuart, William, M.D. & Ch.M., 1881, M.D., 1886, Aberd.
Deane, John Edward James, L.K.Q.C.P. Irel., 1880; L.F.P.S. Glas., 1867.

MEDICAL APPOINTMENTS.

Bray, Percy Dean, M.R.C.S.E., to be Public Vaccinator for Corryong and Tintaldra, Vic., vice W. Gillespie, F.R.C.S., resigned.
Brewer, Henry Edmund, M.R.C.S.E., to be Health Officer for the Port of Portland, Vic.
Cohen, Algernon Aaron, M.D. Aberd., M.R.C.S.E., to be Visiting Surgeon to the Grafton Gaol, N.S.W.
Eadie, John McIntyre, M.B. & Ch.M. Glas., to be Assistant Health Officer for City of Sandhurst, Vic.
Hodgson, Thomas, M.B. & Ch.B. Melb., to be Health Officer of the shire of Bulla, Vic., vice Dra. Turner and Dickenson, resigned.
Manson, John Frederick William, M.B. & Ch.B. Melb., to be Officer of Health of Malmesbury, Vic., vice H. F. Main, M.B., resigned.
Mead, Rivia, M.B. & Ch.M. Ed., M.R.C.S.E., to be Public Vaccinator for Kaniva, Vic.
Griffith, Christopher Arthur, M.R.C.S.E., to be Public Vaccinator for Elsternwick, Vic.
Rogers, R. S., to act as Medical Officer to attend to the destitute poor and aborigines within the District of Port Wakefield, S.A.
Salter, George Herbert, M.R.C.S. Eng., L.R.C.P. Ed., to be Public Vaccinator at Gisborne, Vic., vice A. Plummer, M.D., resigned.
Watt, John Douglas, M.B. & Ch. M. Edin., to be Government Medical Officer and Public Vaccinator for the district of Pictou, N.S.W.

THE report of the New York Post-Graduate Hospital, including the babies' ward, for the twelve months ending May 1, 1887, shows that 4,734 new patients have been treated in the dispensary, and 172 in the wards of the hospital; of the latter 111 were cured, 37 improved, 10 died, 2 did not improve, and 12 remained under treatment; the number of operations performed was 124. In the babies' ward 148 patients were admitted, and of these 31 died, 59 were cured, 51 improved, and 7 did not improve; the number of operations performed was 12.

REPORTED MORTALITY FOR THE MONTH OF MARCH, 1888.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Bronchitis.	Pneumonia.
N. S. WALES.														
Sydney	132,846	330	170	71	3	...	5	...	5	6	18	10	5	6
Suburbs	215,849	812	343	174	5	2	8	...	16	25	29	19	11	12
*NEW ZEALAND.														
Auckland	35,965	74	47	29	...	...	...	3	4	12	2	2	1	...
Christchurch ..	16,217	36	31	14	...	...	1	...	1	5	2	2	...	...
Dunedin	24,334	55	29	3	...	...	...	...	2	1	6	4	2	3
Wellington	28,235	77	23	10	...	...	1	...	1	1	1	...	...	1
QUEENSLAND.														
Brisbane	51,689	184	65	22	}	...	5	1	4	5	16	4	4	2
Suburbs	21,960	113	28	17										
SOUTH AUSTRALIA	312,610	960	301	102	...	1	10	1	17	14	33	22	10	12
Adelaide	43,527	132	67	17	...	...	3	...	9	3	9	5	...	2
TASMANIA.														
Hobart	31,734	98	67	21	...	...	4	...	9	5	9	3	...	1
Launceston	19,562	53	26	6	...	...	...	...	3	2	...	5	...	2
Country Districts.....	91,452	237	79	...	...	...	...	...	...	3	...	...	...	...
VICTORIA.														
Melbourne	69,774	159	189	} 325	...	1	28	...	54	60	65	46	14	16
Suburbs	275,606	1068	658											

METEOROLOGICAL OBSERVATIONS FOR MARCH, 1888.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.			Depth.	Days.		
Adelaide—Lat. 34° 55' 33" S. · Long. 138° 36' E. ....	...	96·8	67·7	46·5	29·988	Inches	...	...	...	...
*Auckland—Lat. 36° 50' 1" S. ; Long. 174° 49' 2" E.	145·	80·5	63·6	49·	...	0·790	5	67	...	...
Brisbane—Lat. 27° 28' 3" S. ; Long. 153° 16' 15" E.	153·8	96·8	72·2	59·1	30·014	0·711	10	65	...	...
*Christchurch—Lat. 43° 32' 16" S. ; Long. 172° 38' 59" E.	151·	86·	59·7	36·	...	2·355	5	61	...	...
Dunedin—Lat. 45° 52' 11" S. ; Long. 170° 31' 11" E. ....	...	...	...	...	...	...	...	...	...	...
Hobart—Lat. 42° 53' 32" S. ; Long. 147° 22' 20" E. ....	...	87·5	57·	37·2	29·869	1·03	11	76	...	...
Launceston—Lat. 41° 30' S. ; Long. 147° 14' E. ....	...	81·	60·2	32·3	29·936	·12	2	67	...	...
Melbourne—Lat. 37° 49' 54" S. ; Long. 144° 58' 42" E. ....	...	94·	60·	42·	29·973	2·16	11	...	...	...
Sydney—Lat. 33° 51' 41" S. ; Long. 151° 11' 49" E. ....	...	92·8	67·7	52·	30·021	1·18	7	60	...	...
*Wellington—Lat. 41° 16' 25" S. ; Long. 174° 47' 25" E.	139·	71·	60·	46·	...	2·634	13	76	...	...

* The Statistics for New Zealand are those of the preceding month.

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

TRACHEOTOMY IN DIPHTHERIA.— NINE CASES—FIVE RECOVERIES.

By F. E. HARE, M.B., M.R.C.S.E., ACTING
MEDICAL SUPERINTENDENT, BRISBANE HOS-
PITAL.

IN an article on "The successful treatment of diphtheria," which appeared in the *Australasian Medical Gazette* of May 15, Dr. Eakins writes "If ever a child was brought to me suffering from this disease, and with decidedly croupous breathing, my prognosis was invariably that the disease would end fatally, because I then knew that the disease had made its way down the trachea too far, and the blood was too poisoned, and the system so far vitiated as to preclude recovery."

This is indeed a gloomy view of the situation, and if generally held, would consign many cases that could be saved by prompt surgical interference, to certain death, for few mothers would allow an operation on their child, unless we could hold out some slight hope of recovery. My own experience is more encouraging, I publish it *in toto*, chiefly as a plea for early tracheotomy, for I may say, I have never deferred an operation on any pretext, without regretting it.

I. Gertrude P., *æt.* 7 years, admitted September 14, 1886. Ill four or five days, throat covered with white patches, respiration croupy, but not distinctly obstructed. 15th, a.m.—Breathing more difficult; P., 136; T., 101.5°; but easier towards evening, and she slept in snatches during the night. 16th.—Spasmodic attacks of dyspnoea became frequent, and ended in continuous obstruction; tracheotomy at midnight; calm sleep during the rest of night. During the next three or four days she coughed up many pieces of thin membrane through the tube, which was permanently removed on the eighth day. Further convalescence rapid.

II. Maggie R., *æt.* 4 years, admitted 9 p.m., April 26, 1887. Respiration croupy, but fairly easy; several small white patches on both tonsils and soft palate; P., 130; T., 102°. 11 p.m.—Dyspnoea marked; very restless, but sleeps in snatches; P., 160. 11.30 p.m.—Tracheotomy after which passed good night, pulse falling to

128 during sleep. For the next two weeks continued to cough up pieces of membrane by the tube. May 2.—T., normal; P., 96; further convalescence was retarded by an attack of dysentery. The tube could not be dispensed with finally until the end of the fourth week. Although for some time she had been able to do without it during the day, dyspnoea invariably came on when she fell asleep.

III. Harry G., *æt.* 2 years, admitted May 10, 1887. Respiration harsh, but obstruction slight; a few white patches on both tonsils. Next day was no worse until late in afternoon, when dyspnoea became urgent. After two or three large doses of ipecacuanha wine, which failed to produce even vomiting, tracheotomy was performed at 7 p.m. Membrane continued to come away in small pieces from the tube for some days. On May 16, convalescence was established, but the tube could not be dispensed with during the night until the middle of the fourth week.

IV. Rosa K., *æt.* 7 years, admitted May 11, 1887. Dyspnoea urgent; face dusky; lips blue; white patches on soft palate and uvula. While arranging for the operation the pulse fell from 140 to 70. Tracheotomy ten minutes after admission. Quiet sleep followed, there being no return of obstruction, but the pulse and temperature rapidly rose, the former to over 200, and death occurred at 7 a.m. on the following morning.

V. Fredk. H., *æt.* 5 years, admitted July 28, 1887, at 1.30 p.m. Intense noisy dyspnoea, pale face and blue lips; surface of body covered with profuse perspiration; T., 101.8°; pulse impossible to count. The symptoms being so urgent the fauces were not inspected. Tracheotomy immediately; on opening the windpipe, several pieces of diphtheritic membrane were expelled. The normal colour returned almost immediately to the face; P., 160. Twelve hours later sleeping quietly; respirations, 40; P., 123. Two small pieces of membrane came away during the following day. There was slight albuminuria. Convalescence was extremely rapid, and the tube permanently discarded on the 6th day.

VI. Ellen B., *æt.* 2½ years, admitted 8 p.m., August 27, 1887, having been ill three or four days. Throat covered with membranous patches; obstructive dyspnoea marked; P., 164; T., 100°. 9.45 p.m.—Tracheotomy; great relief for a time, but the trachea below the opening became involved on the following day, and although membranous casts were twice removed by forceps, asphyxia occurred on the 29th, forty hours after the operation.

VII. Percy H., *æt.* 1½ years, admitted 10 a.m., September 11, 1887, with marked laryngeal stridor and history of sore throat. Tracheotomy at noon; great relief for three or four days, but on the 15th he developed pneumonia, with diarrhoea, probably due in part to the fact that he was teething. Death did not occur until the 25th, 15 days after the operation, and was undoubtedly due to the above-mentioned complications, as there was never any return of obstruction nor any sign of diphtheria at the necropsy.

VIII. Maria M., *æt.* 3¼ years, admitted March 5, 1888, with marked croupy breathing, but no definite obstruction; P., 136; T., 101°. On 6th, increasing dyspnoea necessitated tracheotomy, which was performed at 10 a.m. On incising the trachea a membranous cast came away. The usual relief followed and the case did well until the 8th, when obstruction below the tube came on. Both tubes were removed on four occasions and thick casts of trachea and bronchi removed, with temporary benefit only. Death from asphyxia at 5.30 p.m. on fifth day after the operation.

IX. John J., *æt.* 3½ years, admitted April 10, 1888. White membranous patch on pharynx; respiration croupy, but easy; T., 101.7°; P., 90. 4th.—Passed a very good day; respiration almost normal; T., 99°; P., 84. 12th.—Since 1 a.m. dyspnoea has been coming on; membranous patch on pharynx is larger, and disappears from sight below; P., 140. 11 a.m.—Tracheotomy. 13th.—Several large pieces of membrane came away since the operation, and he passed a quiet, comfortable night. Further convalescence was rapid, and the tube finally left out on the 5th day.

The treatment in all consisted of a half tent over the bed, kept filled with steam impregnated with eucalyptus, sponges wrung out of hot water constantly applied to the tube, and the administration of fluid nourishment, usually milk with from four to eight ounces of port wine, per diem. The first three and the last two were ordered a mixture containing small doses of perchloride of iron, chlorate of potash and glycerine, but the nurse in charge was instructed not to wake the child for it, nor to insist upon its being taken if much objection was raised. I do not think many doses were administered. The other cases had no drugs whatever. In no case was the throat examined after the operation.

In every instance the trachea was opened below the thyroid isthmus, no anæsthetic being used except in case VII., where chloroform was given. No difficulty occurred in the operation except in case IV., where there was some delay in introducing the tube, due to the depth at which the trachea lay, and to the fact that a sufficiently long instrument was not at hand.

In the first two a sharp hook was used to draw the trachea up into the wound before opening it. In the rest, a blunt hook passed beneath the thyroid isthmus and drawn directly upwards was found to give more room and to steady the wind-pipe sufficiently, while it was free from the danger of twisting the trachea and so allowing the incision to be made laterally. Should the isthmus have been wounded, as happened once to me, the blunt hook can be replaced by pressure forceps, which will then serve the double purpose of controlling hæmorrhage and steadying the parts.

The above cases would appear to show—(1.) That no case is too bad for operation; (2.) That when, in the course of diphtheria, it becomes evident that the air passages are involved, the sooner the wind-pipe is opened the better, and that it is not advisable to wait until obstruction becomes marked; (3.) That drugs and local treatment are unimportant.

SUCCESSFUL CASE OF OVARIOTOMY.

READ BEFORE THE QUEENSLAND MEDICAL SOCIETY
ON MAY 15, 1888.

By E. MATTHEWS OWENS, HON. OPHTHALMIC
SURGEON TO CHILDREN'S, BRISBANE, IPS-
WICH, AND TOOWOOMBA HOSPITALS,
QUEENSLAND.

Miss S., *æt.* 37, a healthy-looking woman, consulted me on Feb. 11 of this year, about a tumour that she had been suffering from for some time. The history she gave me was, that from 16 to 23 her menstrual periods had been irregular, but from 23 to the present time she had had nothing to complain of in that respect, and had always had good health, except an occasional attack of dyspepsia. Fifteen months ago noticed a swelling in the abdomen, which has increased rapidly the last four months; has never suffered any pain from the tumour, but discomfort at times. Mother and father both alive and well; family history good; English, born in Essex; been in colony two years.

I found, on examination, that the abdomen measured 33 inches. On the right side of the median line there was a prominent tumour which

gave a fluctuation wave in some directions but not all over; it felt thickened and nodular posteriorly.

Deep down in the iliac region of the left side could be felt a second tumour, which seemed to be quite distinct from the ovarian tumour of the right side. I made this second tumour out as ovoid in shape, rather flattened; I could not perceive any fluctuation; walls were smooth.

Per vagina.—The uterus was freely moveable, but tilted forward and slightly enlarged. The tumour of the right side could be felt in the right side of Douglas pouch and gave distinct fluctuations. The edge only of the tumour of the left side could be felt in Douglas' pouch; no connection between the two tumours could be distinguished.

I diagnosed the case as an ovarian tumour of the right side. The secondary tumour as most likely to be a dermoid.

She was most anxious to be operated upon at once, the weather, however, being hot and oppressive, I thought it wiser to postpone the operation until April, so she went to Toowoomba to recruit, and on April 10 she was admitted into Miss Doggette's Hospital, and on the 11th, at 8.30 a.m., I proceeded to operate.

Dr. Clowes again did yeoman service in the way he administered chloroform. Drs. Waugh and Thorpe were present as visitors. I kept to my usual practice of having only one assistant, and this was Dr. Lyons, who left nothing to be desired.

I was most anxious to keep the incision as small as possible in this case, and was greatly disappointed in having to enlarge (for reasons I will presently mention) from $2\frac{1}{2}$ inches to $3\frac{1}{2}$.

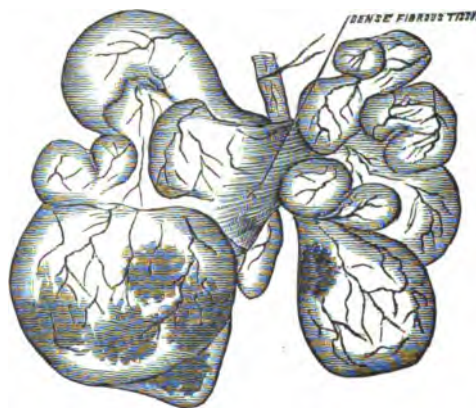
After making the usual incision of $2\frac{1}{2}$ inches, I opened the peritoneum, and in passing my fingers round the tumour to feel what adhesions I had to deal with, if any, I found I had complications to overcome. I first punctured the cyst that presented, and seized the edges with Nelaton's forceps, after about 8 ozs. of fluid had been evacuated, but I did not find matters much clearer, for the tumour seemed enveloped in intestines. I therefore enlarged the incision, and passed my whole hand into the abdominal cavity, where it first encountered a number of nodular masses in the right side, all of which contained more or less fluid. Opposite the median line I came upon a dense, fibrous structure, extending from the right to the left side, and lying over it, or, perhaps it would be better to say, fitting into and coiled round this fibrous structure was a coil of intestine. I carefully traced the structure to left side, and found it was connected with the tumour of the left side, and therefore I had only one tumour to deal with after all.

As the intestines were so mixed up with the tumour I did not dare to pull it, I therefore punctured as many as possible of the smaller cysts, allowing their contents to drain into the abdominal cavity. By this means I was enabled to reduce the size of the tumour, and uncoil the intestines from it. It put me very much in mind of freeing the cord from the neck of a child as it is being born.

The pedicle I found to be rather large and fleshy, so that I tied the fallopian tube separately from the pedicle, securing both with Chinese silk, and dropped them into the abdomen. It goes without saying that after there had been so much fluid allowed to go into the abdomen I was most careful of the "toilet of the peritoneum." I put in a drainage tube for safety, but it was not really required, as there was little or no oozing. The abdominal cavity was not washed out as I did not consider the fluid of a character likely to set up mischief. I examined the right ovary. It was quite healthy.

There having to be so much manipulation, the patient was under chloroform 80 minutes.

DIAGRAM OF THE OVARIAN TUMOUR REMOVED.



MICROSCOPIC EXAMINATION, BY SURGEON V. G. THORPE, R.N., OF FLUID CONTENTS OF OVARIAN TUMOUR REMOVED BY MR. E. M. OWENS.

Colourless, glairy, with whitish deposit. Contains degenerated blood corpuscles, large fat granules, and cholesterine crystals. Also squamous and ciliated columnar epithelium. No hydatid hooklets could be detected.

Miss Doggette's diary is so exactly what a diary should be, that I give it *verbatim et literatim*.

April 11.—10.45 a.m., injection $\frac{1}{2}$ oz. brandy, $1\frac{1}{2}$ oz. beef-tea. 12.45, ice and $\frac{1}{2}$ oz. brandy; been sleeping a little and seems very comfortable. 1.15, complained of pain and passed a great deal of

wind per mouth, which relieved her. 2.45, emptied drainage tube, and gave a little ice with one dessert-spoonful of brandy; temperature 98°6'; amount of fluid drawn off, five drams. 4.25, much troubled with wind after sleeping from 3 p.m. until 4 p.m.; gave ice; gave cajuput oil on sugar, which relieved her much. 6 p.m., complained of feeling sick, and threw up a little water, passing also much wind at the same time; gave ice. 7 p.m., much troubled with wind, and complains of sickness; has been restless since 6 p.m.; temperature, 100°4'; gave ice. 7.35 p.m., brought up a little bile; much troubled with a feeling of sickness; gave ice. 8.30, Dr. Owens visited and emptied the tube; temperature, 98°4'; gave soda water. 9.20, brandy and water; passed catheter. 11.20, no sleep, so gave, draught; much troubled with flatulency and a desire to vomit.

April 12.—1 a.m., been sleeping since 11.40. 3.35, been sleeping since 1 a.m.; gave a little brandy and soda with ice; no flatulency since 11.30 last night. 5 a.m., was slightly restless and had much flatulency; gave warm brandy and water. 7 a.m., has slept from 5.10 a.m. very comfortably; gave warm brandy and water; temperature, 98°8'. 8.40, tried to pass catheter, but could not manage it as patient said it hurt her too much. 9.40, Dr. Owens visited and found patient comfortable; emptied drainage tube, and relieved bladder; ice and brandy, then dozed until 11.30 a.m.; brandy and soda water; less flatulency since the Doctor's visit, and a good sleep, lasting until 12.48; vomited a little bile. 1 p.m., restless and uncomfortable, complaining of thirst, and pain in the lower part of abdomen; gave warm brandy and water, after which she went to sleep; temperature, 101°; face very flushed. 2 p.m., been sleeping 40 minutes; face not so flushed. 3.20, been asleep since 1.20; being thirsty, had a little soda and brandy; face less flushed; is troubled a little with flatulency. 5.30, less hot and flushed; temperature, 99°8'; been sleeping a great deal; had 6 oz. of gruel. 7.35, passed catheter and relieved bladder; ice and a little soda water; seems very comfortable and inclined for sleep; 9.40, cup of gruel and a little ice; has been resting over an hour and a half; drew off fluid from tube; 10.40 p.m., Dr. Owens visited, but hearing patient was asleep, did not see her. 11.40, been sleeping quietly since 10.10 p.m. 12.40, awoke and complained of pain, gave warm brandy and water; temperature 100°; removed drainage tube.

April 13.—1.10 a.m., sleeping comfortably. 2.30, been asleep since 1.10. 4.38, still asleep, and very comfortable. 6 a.m., awakened and asked for a drink, had soda and brandy; temper-

ature, 99°4'; says she feels very much better; passed catheter and relieved bladder. 7, cup of gruel. 8.45, brandy and soda water. 9.35 a.m., Dr. Owens visited and re-dressed wound. 10 a.m., gave cup of gruel. 11.30 a.m., brandy and soda water. 12.30, had cup of gruel. 1.45, brandy, ice and soda water. 3.30 p.m., been sleeping since 2 p.m., gave a cup of gruel. 4.30 p.m., brandy and soda. 5.10 p.m., temperature 99°; has had a very comfortable afternoon. 6.30, cup of gruel. 7.10 p.m., passed catheter; gave soda and brandy. 9.15 p.m., Dr. Owens visited; temperature, 98°6'. 9.48, cup of gruel. 10.40, warm brandy and water; passed wind per rectum. 12 midnight, been sleeping an hour, awoke and complained of pain; gave cajuput oil.

April 14.—2.10 a.m., been sleeping but little; has little dragging pains in the lower part of abdomen. 6.45, been asleep since 2.30 until 6.30 a.m.; temperature, 98°4°; gave cup of gruel. 9.30 a.m., Dr. Owens visited, and ordered patient fish and custard pudding. 9.48, gave a cup of gruel. 12.30, been asleep since 10 a.m.; gave some boiled fish, and brandy and soda. 2.45 p.m., gave brandy and soda, and baked custard. 5 p.m., passed catheter and relieved bladder; temperature, 98°4°; a cup of gruel. 7.30, brandy and soda. 9.15, passed catheter, and gave a cup of gruel; had a nice day. 9.45, asleep, and comfortable; had no pain or discomfort to-day.

April 15.—5 a.m., been sleeping since 9.45 last night; gave soda and brandy. 6.45, gave gruel, and passed catheter; temperature, 98°4°; passing wind naturally. 8.20, brandy and soda. 10.5 a.m., a cup of gruel. 12, custard pudding, and brandy and water; seems very bright and comfortable. 2 p.m., minced mutton; brandy and soda. 3.30 p.m., Dr. Owens visited, examined wound, and took out the stitches; gave brandy and soda. 4 p.m., a cup of gruel. 6 p.m., a cup of beef-tea; temperature, 99°; passed catheter. 8 p.m., brandy and soda; had a nice evening. 9 p.m., passed catheter, and relieved bladder; gave cup of gruel; passes wind naturally, but has very little flatulency. 10.10 p.m., sound asleep.

April 16.—1.15 a.m., still sleeping. 3.15 a.m., awakened, and complained of pain; gave cajuput oil and hot brandy and water, which expelled the wind, and gave ease. 3.40 a.m., asleep, and comfortable until 5.10 a.m., then had pains, and at 5.15 a.m. passed water naturally; has slept well through the night. 6 a.m., a cup of gruel; temperature, 98°. 8.30, brandy and soda. 9.10, a cup of gruel. 10.50, a cup of beef-tea. 12.50, minced chop, and brandy and water. 3.30 p.m., a cup of gruel. 5.10 p.m., Dr. Owens visited, and re-dressed wound; temperature, 98°2°.

6.15, boiled fish, soda and brandy. 9.15 p.m., a cup of beef-tea; been comfortable all day. 11 p.m., been asleep since 9.30; gave a drink, brandy and soda; has passed water naturally all day.

April 17.—5.55 a.m., been asleep since 11.10 p.m. last night; gave cup of gruel; temperature, 97.6°; says she feels quite well. 8.30 a.m., a cup of beef-tea. 10, warm brandy and water; had a little difficulty with the water, so passed catheter, and relieved bladder. 10.45 a.m., a cup of gruel. 12, noon, brandy and water. 12.45, boiled chicken, brandy and water. 3 p.m., been sleeping since 1.20; beef-tea. 5.15 p.m., gave a cup of gruel; temperature, 98.4°. 6.30 p.m., boiled fish; brandy and soda. 8.30, brandy and soda water. 9, beef-tea; has had a nice day, and seems very comfortable.

April 18.—6 a.m., has slept since 9.30 last night; temperature, 98.2°. 7 a.m., a cup of gruel. 2.15, gave a cup of beef-tea. 11.15, oysters. 1.30 p.m., beef-tea. 3.15, a little chicken (boiled). 3.30, Dr. Owens visited. 6.30 p.m., temperature, 98.8°; has had a little flatulency since 5.35. 9.15, very comfortable.

April 19.—6.30 a.m., has slept from 10 p.m. last night; temperature, 98.2°; says she feels quite well. 1 p.m., roast mutton; bowels uncomfortable; gave an enema, 4 ozs. oil. 3.40, bowels relieved very comfortably; Dr. Owens visited. Evening temperature, 98.4°; has had a capital day.

April 20.—6.30 a.m., had a good night; temperature, 97.8°. Was on the sofa one hour; had to eat, oysters and boiled fish, with a baked apple and bread and butter. Evening temperature, 98.6°; Drs. Owens and Waugh visited; had a capital day, and a visitor.

April 21.—6.30 a.m., has slept well all night; temperature, 98°. 4, was on the couch two hours and ten minutes; has a good appetite, and is very bright and cheerful; gave her to eat, fish, mutton, bread and butter, oysters, and a baked apple; had a very comfortable day. Evening temperature, 98.6°.

April 22.—Slept the whole night; temperature, 98.3°; says she feels splendid; Dr. Owens visited, looked at wound, and pronounced patient well. On the couch 3½ hours.

23rd.—Has catamenia, which is right up to date, the last period being March 26.

Remarks.—It may be said, Why read notes of such a simple case, as it only required a little more manipulation to extract than is usual? Had this been all, I most certainly should not have recorded the case, but there are one or two points of great interest that must not be overlooked.

First.—How unwise it is to give a pronounced diagnosis in these abdominal cases until you have

opened the abdomen, and really felt and seen what you have to deal with. I most certainly thought I had two distinct tumours to deal with, and yet, all the time there was but one. Two or three medical men had also seen the case and pronounced that two tumours were present. The tumour evidently sprang from the left ovary, grew steadily to the right side and then must have taken on again fresh growth towards the side it sprang from first; doubtless the tying down had something to do with this. It appeared strange to me that there had not been more abdominal distress with so much displacement. I also consider it was most fortunate that no twisting of the intestines had taken place at any period.

Second.—I made a grave mistake in allowing this patient to come into the hospital only the day before the operation. If she had been in a bad state of health it would not have so much mattered, but here was a fairly robust woman, eating most likely, heartily, and perhaps had not curbed her appetite, yet she went at once under a severe operation; was it not likely, that the high temperature and vomiting was not due to the operation at all, but induced by bilious irritation. Therefore, I would add to what I have said in my paper on "Ovariectomy" about "Preparation of the Patient," let the patient be under careful observation for a few days before the operation. This will give an opportunity for her diet to be regulated, increased or diminished, according to her general condition.

Third.—This case also teaches how little functional disturbance takes place in a successful ovariectomy. Her menstrual period came on the twelfth day from the operation, and to the exact date that was usual.

It will be seen also, by diary, that no notice is taken of the pulse. I am quite indifferent about the pulse being registered, in fact, I prefer that no notice should be taken about it in these cases, as long as the tongue is moist and temperature is low, the less the patient is worried the better. There is always something alarming to a patient if the taker of the beats does not control the countenance while looking at the watch, and this is difficult to do when you find a pulse registering 130 or 140, which you did not expect. Whereas the thermometer is taken to the light, and whatever it indicates nothing is seen by the patient.

This makes my third successful case since December, and not one of them what I should choose as a simple uncomplicated ovariectomy, therefore, I think it can be put aside for ever that Queensland climate is not suitable for the performance of abdominal section.

**HYDATID OF THE RIGHT LUNG—
SIMULTANEOUS RUPTURE INTO
THE PLEURA AND THE BRON-
CHIAL TRACT—LOCALISED PLEU-
RITIC EFFUSION — PNEUMO-
THORAX—OPERATIONS—CURE.**

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J. L. L., residing at Yatala, near Adelaide, con-
sulted me on September 5, 1887.

History.—He was born at Kingston, in the
south-eastern district of South Australia. It
is not probable that he acquired his infection here,
for when the patient was three months old his
parents removed to Yatala, where for the greater
part of his life the patient has lived. He had
enjoyed good health until about five or six months
ago, when he began to be troubled with pain
about the angle of the scapula, this was sufficiently
severe to induce him to consult a medical man,
under whose treatment it disappeared for about a
fortnight and then returned. Suddenly, about six
weeks ago, a violent fit of coughing occurred,
accompanied by a copious expectoration of frothy
fluid, amounting, the patient thinks, to a pint
and a half in quantity. Somewhat severe dyspnoea
came on at the same time, and lasted for a few
hours; neither blood nor hydatid membrane
were noticed in the sputa. Almost simultaneously
with the cough and dyspnoea, an attack of urticaria
came on. In the course of a few hours the cough
diminished in violence, but it has continued to a
less extent up to the present time. In consequence
of the attack just mentioned, he kept his bed for
about a fortnight, during which in addition to
cough, dyspnoea and expectoration, he suffered
also from pyrexia, which occasionally reached a
height of 101°. His medical attendant suspected
hydatid disease.

Present State.—September 5, 1887.—There was
impaired mobility of the whole right chest; in front,
dulness below the third rib in the right nipple
line, but within this line was a wedge-shaped area
of tympanitic resonance which corresponded to
the inner end of the third rib and of the third
interspace; the upper line of dulness in front,
therefore, was strongly curved, with a convexity up-
wards. Posteriorly, dulness reached from the ex-
treme base upwards in the scapular line to a level
about two fingers' breadth above the angle of the
scapula; towards the spine the upper line of
dulness descended rapidly, so that behind, as in
front, the upper line of dulness was markedly
convex. Above the area of dulness, at this time,

no conspicuous alteration, either of percussion
note or of auscultatory sounds, was observed. Over
the region of dulness there were loss of vocal
fremitus and of respiratory murmur; the cardiac
apex-beat was felt in the fifth interspace, slightly
outside the left nipple line. Nothing abnormal
was discoverable in the left lung.

The diagnosis arrived at was that of an hydatid
at the base of the right lung, which had ruptured
and partly evacuated its contents into the pleural
cavity. It was tolerably certain that the cyst
contained clear, normal, hydatid fluid, for this
alone appears to be capable of causing urticaria,
when effused into the pleural or peritoneal cavity.

On September 11, with the assistance of Drs.
Way and Lendon, I made an incision in the
eighth interspace in the posterior axillary line.
A considerable amount of pleuritic fluid, which
coagulated, spontaneously escaped, but no special
hydatid products. An exploration with the finger
showed that adhesions existed, which enclosed a
moderately large space filled with ordinary pleuritic
fluid. The lung within reach appeared to be
compressed, but not otherwise altered. An india-
rubber drainage tube was introduced, and ordinary
antiseptic dressings of Hartmann's "Wood
Wool" and oakum were applied. A very mod-
erate amount of discharge took place from the
pleural space which continued aseptic, but in
spite of this the patient became decidedly worse.
He slept badly at nights; he had pyrexia, es-
pecially in the evening, when the temperature
ranged from 101° to 102°. On the morning of
September 17 (six days after the operation), he
had a rigor, followed by a rise of temperature to
104°; his respirations became frequent—usually
about 40 per minute; his pulse frequent, and his
cough well-nigh incessant. The discharge from
the wound, however, was scanty, not purulent, and
quite aseptic. It was obvious, therefore, that
some condition was present other than the state
of the lower section of the right chest, and a care-
ful examination of the patient showed now, signs
of pneumothorax, especially manifest in the
right infra-clavicular and mammary regions.
An exploratory puncture made with an aspirator
needle gave exit to foetid gas, and consequently I
made an incision in the third interspace, one half
inch outside the right nipple line, and in order
more effectually to drain the pleural cavity I
made a counter opening in the sixth interspace, a
little in front of the mid-axillary line. A large
quantity of highly foetid, thin, purulent fluid and
gas escaped. The cavity was washed out
thoroughly with boiled water and boro-glyceride,
large drainage tubes were inserted and the usual
antiseptic dressings were applied. The patient
improved somewhat, but still continued very ill

and extremely short of breath ; for the left lung, which alone, of course, was operative in respiration, became clogged with rales and the respiratory murmur in places acquired a bronchial character. However, on the evening of the fourth day after the operation the discharge had diminished in amount and in fœtor, and shreds of hydatid membrane escaped through the large drainage tubes ; the lung, too, commenced to expand so as to push out the upper drainage tube, especially during the act of coughing.

On September 25, I thought it advisable to enlarge the opening in the sixth interspace in order to supply free exit for the hydatid membranes and pus. For this purpose, an inch and a half of the sixth rib was excised ; through the capacious wound the index finger could be fully introduced in order to explore the interior of the cavity, but although the lung had expanded considerably, it was not possible to discover the spot at which the hydatid had ruptured into the pleura. It would be alike tedious and unnecessary to relate at length the subsequent history of the case ; it suffices to tell that the fœtor of the discharge rapidly diminished, and finally ceased, that many shreds of mother-cyst and a few ruptured daughter-cysts escaped by the lower wound, and that the general condition of the patient steadily improved, so that on the 38th day after the pneumothorax was operated on he had sufficiently recovered to return to his home, the dressings being changed by his mother when necessary. A fortnight later, the right lung had completely expanded, normal respiratory murmur being audible all over the right chest. In another fortnight all the wounds had healed completely and the patient was quite well.

This case well illustrates the complications which may occur in the course of a pulmonary hydatid.

It seems to me that the following was the sequence of events. The patient had for some time harboured an hydatid in his lung, which, however, had not betrayed its presence by any symptoms sufficiently serious to attract his attention until five or six months before his present illness, when he had pain about the angle of the scapula, then, suddenly, the parasite ruptured into the pleura, this event being marked by an outbreak of urticaria, accompanied by cough and dyspnoea ; simultaneously with the rupture into the pleura there was communication established with the bronchial tract and escape of hydatid fluid into the air-tubes.

The orifice of rupture was evidently small, for at this time the parasite did not escape into the pleura ; moreover, the contents of the hydatid

was healthy hydatid fluid, for it produced urticaria.

As the result of the effusion of the echinococcus fluid into the pleural cavity, an attack, of pleurisy occurred ; the effusion reached nearly to the third rib in front and a little above the angle of the scapula behind, but at its upper level this collection of fluid became enclosed by adhesions which shut out the upper part of the chest space, so that when the fluid was evacuated, no direct connection was established with the hydatid ; still a disturbance took place in the equilibrium of the thoracic cavity, which permitted a certain amount of expansion of the upper part of the lung which enclosed the parasite. And now the contents of the cyst were once again enabled to enter the upper part of the chest cavity ; meanwhile the cyst-contents had become altered owing to the access of air through the bronchial tubes, so that a putrid pyo-pneumothorax resulted. This was operated on, and the lung, which had collapsed as the effect of the pneumothorax again expanded, this time sufficiently to permit the escape of the parasite into the pleural cavity and thence out by the incision wounds.

AN INTERESTING CASE— WAS IT CHRONIC PERITONITIS OR “SPRUE?”

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HAVING read an article on “Pilonis or Sprue” by Dr. Thin, in the *Practitioner* of November and December, 1887, I was reminded of a case of mine, which had presented some unusual symptoms, and having referred to my notes of the case, I found that those symptoms corresponded, in many respects, to the description of sprue. The case had been diagnosed and treated as one of chronic peritonitis, following an attack of acute Bright's disease ; and yet, though there are many symptoms suggestive of sprue, I still adhere to the original diagnosis, for reasons which will be given later on. It is a source of much regret that a *P.M.* was unattainable in this case ; the friends had him removed from the Hospital, in my opinion, to prevent such an examination, though the usual formula was used “of his wishing to die amongst his friends.”

I will now give a full report of the case, and afterwards refer to those characteristics which are considered diagnostic of sprue ; but it might be as well, to give a brief account of that disease as related by Dr. Thin.

This complaint is peculiar to adults who have

resided in the warm climates of China, Java, and the East; its most prominent feature is diarrhoea; the condition of the bowels is irregular; the motions are never healthy, consisting of a frothy, pale yellow or clay-coloured pulpy mass, without any mucous or blood; the mucous membrane of the bowel is not inflamed; the tongue appears as if denuded of epithelium, showing a dry, glazed and shining appearance, the edges of which are moister than the tip, and present transversely, shallow, non-ulcerated fissures; the gums, palate, and oesophagus share in this discoloration, so that at this stage of the disease, wines, spirits, &c., produce a sensation of burning; the mucous membrane of the lips and cheeks, near the angles of the mouth, are frequently raw and tender, and covered with slight abrasions; the liver shrinks from general atrophy; albumen is seldom present in the urine. There is no fever or increase of temperature; but the skin is rough and dry. As the disease advances, the patient, who now has a withered, shrunken, old appearance, becomes anæmic and emaciates rapidly; suffers from flatulence and capricious appetite. Death occurs from exhaustion.

Previous History.—T. K., aged 46 years, a native of Scotland; married, with four children. He was engaged all his life in mining pursuits; he was working in the iron mines at home from boyhood, but during the last 25 years was engaged in gold mining, both in Victoria and New Zealand. His mode of life in the early part of that period was the usual routine of hard work, followed by hard drinking, and its accompanying dissipations. He never travelled beyond the Australian Colonies; and was never laid up from any illness, or an accident, having always enjoyed good health. Of a spare, muscular appearance, active disposition, and sanguine temperament; average weight, 160 lbs.

Family History.—His parents have both been very healthy and long-lived; he had three brothers, all of whom were strong and active men, and one of whom is still residing here. There are no traces of cancer, phthisis, &c., in the family.

History of his Illness.—Whilst at his work in the mine, on June 16, 1886, he received a thorough wetting; he was engaged in "timbering a shaft," through which a stream of water was pouring; yet he worked out his 8 hours, and then walked home, about 2 miles, in his wet clothes. Next day he had several attacks of rigors and vomiting, with pain in the head and back; when visited on the 20th, he was in bed, suffering from anasarca of both legs, extending midway up the thighs, with a swollen face, and puffiness of the lower eyelids, in short, from an attack of acute nephritis. But one unusual

feature in this case was the absence of albumen in the urine, though it was tested for on several occasions; neither was blood nor renal casts detected under the microscope. The urine was neutral; sp. gr. 1015; clear during the first two weeks of his illness, but during the latter, a deposit of lithates, which always cleared up on heating, was present. He recovered in a month, with rest, diuretics, pot. citrate and acetate, jaborandi, &c., and a milk diet; the œdema gradually disappeared, but for a long time after his return to work he complained of a weakness in his lower limbs—in fact, he never regained his former strength. In appearance, he was very thin and pale, with no energy for work, though during the next 8 or 9 months he struggled on; all this time he was annoyed with attacks of rigors, followed by acute diarrhoea; at first he only experienced these attacks once in 2 or 3 months, after a very cold day, but latterly they occurred more frequently, as often as 2 or 3 times a month.

He had a very severe attack of diarrhoea on April 24, 1887, which compelled him to remain in-doors for a week, and from this time he was never free from them, which were certain to occur if he worked in a damp place; even walking to his work on a cold, windy day would induce them. They invariably commenced with rigors, pain in the thighs and lower abdomen, and cramps. The motions at this time were unformed, pasty, of a pale clayey colour, and without any blood or mucous.

Various medicines were given during this period, such as the bromides and opium, iron and quinine, Easton's syrups, and maltine with several combinations, but all were without avail, some even seemed to make matters worse. A milk diet, with cornflour, arrowroot and such farinaceous substances was tried; meat in any form was prohibited, but it was impossible to get him to adhere strictly to the programme; his wife would give him beef-tea, and boil chickens down for him, thus upsetting everything again. On June 4, as he had been confined to his bed for a week, with loose motions, and a gradual wasting, I made a thorough examination, and the following are the notes of the case as then recorded:—

"He is of a very spare and thin appearance, with extreme wasting; the cheeks are flushed, and the conjunctivæ are pearly white; pulse is 100, and temp. is 99°; appetite is capricious, and he complains of nausea after meals, though there has been no vomiting. The tongue is dry, clean, presents no epithelium, is of a red, glazed color, with deep fissures across its upper surface, yet they neither bleed nor ulcerate; the angles of the lips are also sore and cracked, with patches of rough-

ened tissue around them; he complains of the difficulty in swallowing certain substances. The heart, lungs and liver are normal; no tumour could be detected in the stomach or abdomen; no enlargement of the spleen; but there is a certain amount of dullness and fluctuation over the abdomen, below the umbilicus; the bowels are very irregular, with no properly formed motion, and they are generally moved during the night; the urine is normal, clear, usual quantity, and neither albumen or sugar is present. He complains of feeling no pain over the abdomen, only a sensation of chilliness with cutis anserina, when he works in a cold or damp place, or on walking to his work on a cold day. Both the plantar and patellar reflexes are normal; no signs of inco-ordination when walking; the weakness arises from the muscular wasting."

June 30.—He continues in the same state; anorexia; no energy; the bowels are moved three or four times in the 24 hours; the stools are as on previous occasions. When he is at home he does not experience any attacks of rigors, nor pains in the thighs and loins. For the last three weeks he has been unable to work, and he was (July 14) admitted into the district hospital, so as to be more under control.

Treatment in Hospital.—Weight 130½ lbs., P., 110; T., 100° M., 102 8°, E.

Diet to consist of porridge and milk, with tea, in the morning, boiled bread and milk and an egg for dinner, and for tea, milk and bread and butter; no meat, beef-tea or vegetables allowed.

July 15.—He has passed a liquid, whitish-grey motion, with a few pulpy masses in the centre, twice during the 24 hours, occurring about 2 and 7 o'clock in the morning. It takes place suddenly and without any pain; there is no abdominal tenderness, but it is swollen and puffy. He still keeps thin and palid, with projecting cheekbones and pearly conjunctivæ; loss of energy, and muscular weakness. The tongue is in the same state; the angles of the mouth are very sore; there are also some patches of thickened mucous membrane of a whitish colour over the inside of the lower lip. He was put on Syrup Easton ʒiii, tinct. ferri. perch. ʒi, aq. chlorof. ʒi, aq. ad. ʒvi, cap. ʒii bis in die, as well as grs. x pul. Doveri each night.

16.—P., 82; T., M. 99·6°, E., 103°; motions, 2, of the same character and consistence as previously, and taking place about the same hours. The urine, on examination, reveals neither sugar nor albumen, its reaction is acid, sp. gr. 1038, and a deposit of lithates, which clears up with heat.

17.—P., 100; T., M. 102°, E. 101°; motions, 2; pul. bismuth grs. x, was added to the Dover's powder, and one given each evening.

18 and 19.—P., 85; T., 99°-100°; motions, 2. As the iron and Easton's syrup caused nausea, the following mixture was substituted and continued regularly for about a month:—Pul. bismuth, ʒiii; pepsine (scales) ʒii; tinct. opii, ʒii; aq. lauro cerasi, ʒss.; muc. gum tragac. ad. ʒvi, cap. ʒii t-i-d. As he was very anxious for beef-tea he was allowed a basinful for dinner as an experiment; from this date he had half an ounce of whisky at dinner.

20.—P., 80; T., M. 98·8°, E. 100°; he had half a dozen motions last night, which was caused by the diarrhoea; urine tested for albumen by the heat, nitric and picric acid tests, but it was not present; lithates as usual.

21.—P., 80; T. 100·6°-100·4°; the motions are returning to their previous state—there were four during the last 24 hours; examined his body for any patches of bronzing, such as occurs in Addison's disease, but none was found; noticed a few silvery looking striæ, about an inch long, over the inner side of the thighs and around the axilla. The skin is dry, rough and braney; the wasting is very prominent over the upper extremities; the lower half of the abdomen is distended with a dull note on percussion, and fluctuation on palpation; the circumference around the umbilicus measures 29½ inches, whilst midway between it and the pubes it measures 30½ inches.

23.—P., 80; T., M. 100·1°, E. 100·1°; motions, 2; they have returned to the usual greyish-white color, without mucous or blood; there is a tendency to cedema around the ancles, especially after he walks about. This ointment, consisting of pot. iodide ʒii, and lanoline ʒss, was to be rubbed well over the abdomen each night, and he was ordered to wear a layer of cotton wool next his skin.

24-26.—P., 80; T., M. 100°, E. 100·5°; motions, 2; the pepsine mixture was repeated with the addition of another dram of pul. bismuth, also a powder composed of pul. opii. gr. ½, and pul. catechu, grs. xx, was given each night; no albumen detected; no renal casts can be noticed under the microscope; the amount of lithates deposited is increasing.

27-30.—P., 80; T., M. 100·5°, E. 99·2°; motions, 2, which are passed about 6 and 9 o'clock in the morning; the cedema of the ancles is increasing; 20 grains of tannate of bismuth, and the half grain of opium was given each night, instead of the catechu; this powder was given each night without any other alteration, until his death.

August 1.—P., 80; T., 99·5°; motions, 2; he is to have a pint of peptonised milk instead of tea, night and morning.

2-7.—P., 80; T., 100·5°; motions, 1 each morning; they are more consistent and formed than

they have been for some weeks previously, and they are passed after breakfast.

8-10.—P., 100; T., 100.5°; motions, 1; the circumference over the umbilicus is as before, 29½ in.; between that and the pubes it measures 31½ in., being an increase of 1 inch; fluctuation as before; the wasting is visible in all the muscles. The pepsine mixture, peptonised milk, and the tannate of bismuth, are taken daily, also the inunction of pot. iod. and lanoline is persevered in; no albumen by the usual tests; about one-half of the urine consists of a pink deposit of lithates with a trace of bile.

13.—P., 106; T., 101.8°; motions, 1; the legs as far as the calf are swollen, painful and pitting on pressure; his weight is 96 lbs.

16.—P., 140; T., 103°; motions, 1; he is rapidly approaching his end; he is so weak that he can scarcely walk; he falls asleep in all positions and at all times with mental aberration.

17.—Removed home by his friends, who wished that he might die amongst them. On the following day he had a very severe attack of diarrhoea, doubtless caused by some indiscretion in his diet. He died on August 21, having retained all his faculties to the last; death was caused by syncope; he was in the act of filling his pipe, when he fell back on the sofa and expired.

Remarks:—If those diseases of a wasting nature are excluded, viz.: diabetes, Addison's disease, hepatic or splenic cancer, and chronic Bright's disease, there will then remain chronic peritonitis, and chronic diarrhoea or sprue, and the symptoms of both these diseases agree in several respects. Referring again to Dr. Thin's article on sprue, he mentions the gradual muscular wasting, the periodic diarrhoea, with clayey motions and no mucus, the bare, glazed and fissured tongue; he does not find any increase of temperature, and finally, he states that a strictly milk and farinaceous diet has a beneficial tendency on the disease. Now, in chronic peritonitis, there is abdominal tenderness but no acute pain, an enlargement of the abdomen with a limited fluctuation; diarrhoea is generally present when tubercle is the cause; emaciation, with a dry, harsh skin, and pyrexia with irregular exacerbations. Albumen is not always present in acute nephritis, but in chronic Bright's disease, albuminuria and renal tube casts must be present, as they constitute the leading features. This man receives a severe wetting, which induces an attack of acute nephritis, without any albumen in the urine; he quickly recovers from it, but tubercle gradually develops in the peritoneum, causing chronic peritonitis, which progresses to a fatal termination. A detailed account of this case is interesting, if only to show that all the symptoms of sprue may be present,

and yet they are caused by a disease which possesses a definite origin, rapid in its course, and unaffected by drugs.

PROCEEDINGS OF SOCIETIES.

SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

MONTHLY MEETING, held at the Adelaide Hospital, at 8.30 p.m. on Thursday, May 31, 1888. Present:—The President (Mr. Davies Thomas), Drs. Verco, Clindening, H. H. Wigg, A. Wigg, Gardner, Cawley, Mitchell, Aitken, Symons, Giles, Bickle, A. A. Hamilton, Hayward, A. A. Lendon, Jay, Corbin, Stirling, and Poulton. Professor Allen (Melbourne), Dr. Syme (Melbourne), Dr. Bancroft (Brisbane), and Ewbank (College Town), were present as visitors.

EXHIBITS.

DR. GARDNER showed a young woman, formerly suffering from ulcer of the stomach, whose recovery he attributed to the persistent assumption of the prone position after taking food.

DR. A. A. HAMILTON supplied the following notes detailing the previous history of the case:—

Miss Lester, æt. 26, fair health till about 1884. Then had a severe attack of vomiting, pain in epigastric region and back. After some weeks' treatment regained fair health.

In March, 1887, vomiting after food, epigastric pain, and pain behind left shoulder blade, came on again. When first seen by me at this time, she was placed in bed, on strict milk diet, taking about two quarts of milk, with a small proportion of lime water daily. Under this treatment she improved rapidly, and began to go about, and resume her ordinary food. Just then, however, her mother had a severe and prolonged attack of gall-stones. The anxiety and exertion attendant on nursing her mother, threw Miss L. back again. In October she had very severe facial neuralgia, which no treatment, except a local hypodermic injection of morphia and atropia, seemed to alleviate. She then went to Yorke's peninsula, this trip cured her neuralgia, but left the stomach trouble unaltered. She was still in constant pain, both in stomach and back, and vomited everything. About the middle of November she vomited a quantity (about a pint) of pure blood. She was then fed, per rectum, with peptonized milk for seven or eight days.

The hæmorrhage did not recur in any quantity, and she regained strength to a slight extent and was able to go out for change to a friend's house in Kent Town. Here she improved for a short time, never, however, losing the pain in the back of the left shoulder. After a very short time all the old symptoms reappeared in an aggravated form.

During the months that she was under my care her treatment was most varied, and included perfect rest in bed on milk diet, feeding per rectum with peptonized milk, administrations of peptonized milk by the stomach, which, however, did not agree and could not be continued.

Medicinally, she went through almost the whole range of gastric sedatives. Bismuth in different preparations and combinations, hydrocyanic acid, iodoform, nitrate of silver, cocaine, pepsine in different forms, received each a patient trial without apparent benefit.

Hazeline was well retained, and seemed to exercise a beneficial effect on the hæmorrhage. It is worthy of note that for many weeks, when unable to retain any nourishment, porter was retained on the stomach and did not give rise to any pains. I have noticed this fact in other cases of obstinate vomiting, notably in the case of young children, and even infants during the attacks of gastric enteric catarrh so common in summer.

DR. JAY showed a case of chronic enlargement of the cervical glands, materially benefited through treatment by arsenic: also a man on whom he had successfully operated for stone, by the suprapubic method. The stone weighed over 1,000 grs., and the man recovered rapidly, without any troublesome symptoms.

DR. BICKLE showed a boy recovered from compound comminuted fracture of the os ilium, a rather rare and serious injury. The patient was thrown from a cart a few days before Xmas, 1887, on to a piece of rock jutting out of the ground. There was a large flesh wound, big enough to take in the hand, five to six inches long, about two inches wide. The crest was broken off, and the fragments drawn up towards ribs; the muscles were torn through, and the body of the ilium shattered. The loose pieces of bone were removed; it was found, on examination, that the soft parts were torn for more than two inches under skin, beyond posterior angle of wound. A counter opening was made here, and a large drainage tube inserted, the wound closed with deep and superficial sutures, these supported by long strips of plaster and bandages. The bladder, when emptied, was found to contain a large quantity of blood; the peritoneum was not torn through. The youth was unconscious for three days (he lay exposed to the December sun for three hours before discovered). The blood disappeared at close of second day; no peritonitis followed. A portion of wound united by first intention (about $1\frac{1}{2}$ inches), the rest granulated from bottom.

Present Condition: Walks without perceptible limp, can ride, run or jump, and has followed occupation of baker's boy for some two months past. Several pieces of bone were removed during healing process; the ends of the broken crest united to the bone below, leaving an arched space between it and body below. This space, which granulated up and skinned over, is now developing bone.

DR. STIRLING placed on the table a large, loose cartilage removed by him that day from the knee-joint of an adult male.

DR. VERCO showed the head of an ancephalous monster.

NEW MEMBER.

DR. COOKSON was balloted for and unanimously elected a member of the Branch of the British Medical Association.

THE PRESIDENT (Dr. Davies Thomas) mentioned that, in accordance with a resolution passed at the meeting held in May, he and other members of the Council had waited on the Honorable the Commissioner of Public Works and laid before him the views of the Society in the matter of the recent changes in the Hydraulic Engineer's Department—changes which the Society deemed prejudicial to the conservation of the public health. The minister, after listening to the views of the Society, expressed his determination to follow the course he had already determined upon.

At the request of the President, DR. FOULTON re-

mind members of the action they took in March, 1887, as to the threatened pollution of the Hope Valley Reservoir, and stated that, notwithstanding departmental statements then made in answer to the Society's representations, none of the promised changes had been even commenced, and that the houses adjoining the reservoir were still existing and still sources of danger.

MEDICAL REGISTRATION.

DR. CORBIN read a statement detailing the action taken by the Medical Board in the case of a postulant for registration whose only alleged qualification was an American diploma conferred, it was believed, after an insufficient course of study. The Board had hitherto declined to register, but, in view of pressure through the law courts, viewed their position with some anxiety.

DR. CORBIN said: A case that has engaged the attention of the profession, the public, and the law courts off and on for several years has now reached an acute stage, and I thought it might be advantageous to relate the facts to the present meeting and hear what is the feeling of the profession on the subject.

Ten years ago it was found that the wording of the Medical Act, which was passed in 1844, caused an injustice to be done to legally qualified German practitioners who were not graduates of a University. The law did not recognise the holders of the Staat's Examen Certificate. In consequence, an amending Act was passed in 1880, and neither the Medical Board nor any other medical authority was consulted. The consequence was that the clause of the Act intended to legalise the qualification held by gentlemen who had passed the Staat's Examen is so loosely worded that under it a person holding an American diploma, no matter how worthless as a certificate of competency, provided it is recognised in one State of the Union as a legal qualification in that State, alleges he can claim to have that diploma recognised and himself registered as a qualified practitioner in this colony. Shortly after the passing of this Act Mr. Bollen, of Port Adelaide, presented a diploma of Doctor of Medicine which had been granted to him by the Hahnemann College of Chicago, and which is recognised as a legal qualification in the State of Illinois. It was a fact within the knowledge of anyone who would take the trouble to search the passenger lists of vessels leaving and arriving at Port Adelaide that Mr. Bollen was only absent from the province 12 or 14 months on his quest for a diploma. It is not, I think, an unfair deduction to draw, that the Hahnemann College of Chicago does not require from its graduates a course of instruction at all approaching in length or completeness to the minimum required by all licensing bodies in the United Kingdom. This is the opinion of the Medical Board, and they hold that the diploma in question is not one whose admission to the list of qualifications in the schedule to the Act was intended by the framers of the Act of 1880. They maintain also that the word "State" means, and was intended to mean, "Sovereign State," and that when used in connection with America it means the United States as a sovereign power, and that a State Government Appointment means an appointment under the Federal Government of the United States. In this opinion the Board is fortified and upheld by the opinion of the Crown Solicitor, therefore the Board declined to register Mr. Bollen's diploma.

In 1886 that gentleman instructed a firm of legal practitioners to demand his registration, which demand the Board continued to resist. In 1887 another firm of solicitors forwarded to the Board, on Mr. Bollen's behalf, affidavits by persons resident in Chicago, which set forth with much detail how the diploma of the

Hahnemann College qualified its holder to practice in all branches of medicine in the State of Illinois and in all States of the Union, and to hold appointments under the Government of the State of Illinois, but one of the affidavits distinctly states that for an appointment under the Federal Government the holder of this diploma would have to undergo a further examination. The Board replied that the evidence furnished by the applicant's own affidavits was sufficient to prove that this diploma was not one it could register under the provisions of clause 12 of the schedule of the Act. In reply to this objection comes another affidavit in April of this year, in different wording, and appearing to show that the qualification in question *does* entitle its possessor to hold an appointment under the Federal Government; but the opinion of some of the Members of the Board is that this is a mere verbal quibble. Unfortunately the Crown Solicitor has expressed his opinion that this last affidavit should satisfy the Board that the diploma fulfils the requirements of the Act. Under these circumstances two members of the Board were deputed to wait on the Attorney-General and obtain his advice. He said if the Board would furnish him with a memorandum of the reasons they had for differing in opinion from the Crown Solicitor he would have the whole case looked into and would advise us further. The following are the reasons why the Board does not consider it ought to register Mr. Bollen's qualification:—

The Board has declined, and still declines, to register Mr. Bollen on the following grounds:—

I. The diploma which he presents is not one which is recognised by the General Medical Council of the United Kingdom, or the Medical Boards of the Australian Colonies.

II. Advantage is taken by the applicant of clause 12 of the schedule of the Act No. 193 of 1880, this clause having been passed to meet the case of certain German practitioners who, having received a complete medical education, are legally qualified in Germany, but, by the wording of the Act 17 of 1844, were not eligible for registration in this province.

III. The Board still holds the opinion that the diploma of the Hahnemann College of Illinois does not entitle its possessor to hold medical appointments under the Federal Government of the United States.

IV. A literal interpretation of clause 12 of the schedule violates the spirit of the other 11 clauses, which implies on the part of candidates eligible for registration a minimum course of three years' medical study, and the Board holds that it would be a violation of the Act to register a diploma from any medical school which omits or curtails, below the standards of the licensing bodies mentioned in the Act, the period of medical study.

V. The Board is satisfied that the medical school from which the applicant obtained his diploma does not require the minimum curriculum of study.

VI. The Board is further of opinion that by accepting the diploma in question, and so disregarding recognised standards of medical education, it would be doing a wrong to the gentlemen whom it has already registered, as well as those whom it has refused to register.

The position of the Board is this: if the Attorney-General agrees with the Crown Solicitor, and says this diploma ought to be registered, it would violate its sense of right and be false to the duty it owes to the medical profession and the public if it were to place the name of the holder of such a qualification on the roll of registered practitioners.

There are, then, three courses open to the Board.

1. To resign rather than register.

2. To register and then resign, for we could not continue to administer an Act that compels us to sacrifice in such a manner the interests of the profession and the public.

3. To refuse to register, and fight the matter out.

The Government might refuse to accept our resignation while we continue contumacious, so we may find the first course closed to us.

To register the diploma in compliance with anything but absolute force seems to me an abandonment of our trust. In all probability Mr. Bollen, who has already once applied to the Supreme Court for a mandamus to compel us to register him, would renew his application, and we should not have the advantage of the aid of the law officers of the Crown in resisting the application.

Now it is a very noble thing to suffer for a great principle, but I suppose the Medical Board has less personal practical interest in carrying out its duties, so far as they relate to keeping the names of irregular practitioners off the roll, than any other eight men that could be found in the profession, and we are inclined to hesitate to place ourselves in the position of being mulcted in an indefinite amount of costs if we are unable to persuade the judges of the Supreme Court that our reading of the law is the correct one, while, even if successful, a considerable expense is almost certain to be incurred.

The practical point seems to me to be: Is the principle involved important enough for us to fight in its defence, and will the profession at large undertake to secure us against pecuniary loss.

DR. HAYWARD sympathised with the Board. Their position with reference to this case was a difficult one. He thought the Board should resign rather than register, by compulsion, an individual whom they did not consider qualified to practice. They had, however, in accepting office, taken upon themselves certain duties and responsibilities. These they must carry out be the consequences what they might. It was incumbent upon them to act of their own motive, and to seek the support of the profession after coming to a final determination. He viewed the matter not only with reference to an individual case; a general principle was involved. The whole question was a most important one, and he hoped the Board would take a very firm stand.

DR. STIRLING said he was a member of the Board who differed altogether from other members as to the proper course of action in this case. Members generally were in favour of resigning office sooner than register against their better reason; but he (Dr. Stirling) would point out that the Board is appointed by the Government to carry out a certain law whether they liked it or did not like it. They had accepted office, they must administer the law. It was, he thought, incumbent on them to accept, having asked for it, the opinion of the legal advisers of the Government under whom they worked. The Crown Solicitor had already expressed his opinion that they must register this particular applicant. The matter, with some additional information, had been placed before the Attorney-General. Should his opinion run with that of the Crown Solicitor, he did not see that the Board had any other course before them but registration on demand. But without doubt, though the letter of the law might compel registration in this instance, its spirit was certainly adverse to such a course. He advocated registration only under protest, and by submission to the opinion of the legal advisers of the Government, and afterwards immediate resignation of the Board in a body. Such action would, he thought, compel better legislation.

He sympathised with the Board in their difficult position, though he differed from them in their present judgment.

DR. GARDNER thought the Board should not be bound down by legal technicalities, and by an unwise and ancient enactment. They should be guided by the spirit of the Act, and by their own opinion as to the propriety of registering any individual whose diplomas they considered worthless. He was strongly in favour of resigning office rather than registering by compulsion.

DR. CLINDENING sympathised with the Board in its dilemma as constituted, and considering all the facts of the case he saw nothing for them but to register in this case; but he thought they should not continue to act thereafter, but resign rather than continue to administer under faulty and imperfect legislation.

Several other members having spoken, the President invited Dr. Bancroft, the president of the Queensland Medical Board, to tell the meeting how they dealt with doubtful diplomas in Brisbane.

DR. BANCROFT said numbers of men had come before his Board holding various American diplomas. They had found these diplomas were granted after such irregular and inefficient courses of study, that some of the holders of them were of such doubtful repute, that they now declined and had for some time refused to register any such diplomas, and his Board were upheld in this action by the legal advisers of the Government.

DR. VERCO advocated a temporising course—he would first wait for the opinion of the Attorney-General; he would have the matter of the discrepancies in the affidavits seen into; he would refer the whole case again for legal consideration; he would then require, through English Consul, additional attestations as to the school conferring the diploma, and, did no loop-hole appear by which the Board might avoid registration after the fullest inquiry, he, with Dr. Stirling, would advise compliance with the law and then the resignation of all the members of the Board.

PROFESSOR ALLEN, invited by the President, detailed the effective measures taken in several instances by the Victorian Board, to the exclusion of men holding doubtful foreign diplomas. The Victorian Act specified graded courses as a necessary preliminary to the holding of a registerable diploma. This happy word "graded" had been of much service to the Victorian Medical Board in keeping out of the register unqualified holders of worthless American diplomas.

THE PRESIDENT thought the opinion of the Crown Solicitor must guide the Board with regard to registration, but if they thought it contrary to the spirit of the Act they might resign; if not allowed to resign they should register, and then resign.

DR. GILES moved, and DR. CLINDENING seconded the motion: "That this meeting desires to express its confidence in the Medical Board."

DR. BICKLE moved as an amendment: "That this Association, recognising the fact that the Medical Board exists for the protection of the public, and believing that the registration of doubtful diplomas is contrary to the functions of the Board in protecting these interests, supports the Board in its endeavour to exclude from registration any diplomas concerning which it is not fully satisfied."

The amendment was seconded by DR. LENDON, but being put, was lost. The original motion, being put, was carried.

The usual hour for closing having passed, papers by the President, Dr. Bickle, and Dr. Gardner, were held over for the next meeting.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE 70th General Meeting of the Branch was held in the Royal Society's Room on Friday, May 4, 1888, at 8 p.m.

Present:—Dr. Chambers (President) in the chair; Drs. Sydney Jones, Crago, Roth, Macdonald, Martin, Marshall, Knaggs, Parker, Brady, Worrall, Fiaschi, Garrett, Kendall, Clubbe, West, Twynam, and Scot-Skirving.

The minutes of the previous meeting were read and confirmed.

DR. CRAGO read some notes on a case of Morphia Poisoning.

THE PRESIDENT (Dr. Chambers) said that, in discussing this paper of Dr. Crago's, it gave the members a chance of discussing the whole matter of morphia poisoning. The great difficulty in the case mentioned by Dr. Crago was that there was no knowledge as to whether the man really had taken morphia. Goltz's experiments in this connection are interesting, demonstrating very clearly that exactly the same stages of loss of function are found in morphia poisoning, as are seen in removing successive portions of the brain of animals from above downwards.

DR. BRADY remembered a case in which a patient took two ounces of opium. The patient was paralysed, but artificial respiration was kept up by the late Dr. Fortescue and himself, and large doses of atropine were administered, and the patient recovered.

DR. SCOT-SKIRVING said that the most interesting point to him in Dr. Crago's paper was the partial improvement of the patient followed by the subsequent relapse of the symptoms. He had seen, certainly, two such cases. Also at the Prince Alfred Hospital he saw a patient who had tried to hang herself. First a partial recovery took place, lasting for some hours, followed by relapse into unconsciousness, and death. The conditions of opium poisoning and strangulation were somewhat analogous. He would ask what was the mechanism of death in such cases of partial recovery and then relapse. Several explanations might be given.

DR. KNAGGS said:—We are greatly indebted to Dr. Crago for directing our thoughts to this subject. He (Dr. Knaggs) had been attending the Criminal Court all day as an expert in a case of morphia poisoning, and he had been particularly struck with the great diversity of opinion amongst the medical experts in this matter. The patient mentioned in Dr. Crago's paper does not seem to have been used to taking morphia. The secondary symptoms mentioned by Dr. Scot-Skirving were no doubt brought about by the congestion of the nerve centres, leading to a subsequent serous effusion. He (Dr. Knaggs) remembered a case of a young woman who was partially drowned, and was brought round and went on well for a time, but relapsed and died; upon examination it was found that there was a large effusion on the brain. The mechanical conditions were certainly somewhat the same in morphia poisoning, strangulation, and drowning. He had had several *post-mortems* of cases of morphia poisoning, and had always found a great deal of effusion.

DR. SYDNEY JONES said that Dr. Crago need not have apologised for bringing these notes before the members, as they had led to a useful discussion. He (Dr. Jones) did not quite see that there was sufficient evidence to justify the diagnosis of morphia poisoning, as the man's statement as to taking morphia pills, could not be relied upon, especially as the man was in such a confused condition. The results of a limited hæmorrhage into the pons varolii were wide spread, and more in keeping with the symptoms described, and he should think that the cause of death had been some subsequent inflammatory mischief. In support of this view of the case was the total absence of that coldness and clamminess mentioned by the authorities as distinctive of opium poisoning.

DR. WEST said he was called to a case on Sunday last with sudden embolic hemiplegia. The patient was a confirmed morphomaniac, who took as much as 3 grains in 24 hours. The patient had formerly consulted Dr. MacLaurin, who advised him to give up the habit, and he had in consequence reduced the allowance to $\frac{1}{2}$ grain in the 24 hours. The question then arose as to whether he (Dr. West) should stop the morphia; the patient begged that he might continue it, and, after consultation with Dr. MacLaurin, he (Dr. West) decided to let him continue the $\frac{1}{2}$ grain.

DRS. MACDONALD, WORRALL, and TWYNAM also discussed the paper.

DR. CRAGO thanked the members for their criticisms, and said as regards the rigidity there was simply none at the beginning of the case, neither were there any true convulsions throughout the case. He (Dr. Crago) regretted that there was no evidence as to the amount of morphia taken by the man. On looking up the authorities in this case he found that the amount of atropine he had administered was scarcely sufficient to act as an antidote. The man was not addicted to taking morphia, and his mental condition was quite clear when he made the statement that he had taken morphia pills. Authorities differed considerably in their account of the symptoms; for instance, one mentioned the cold surface, and another warmth of the skin. Perhaps these discrepancies arose from idiosyncrasies in the patient, or from different time of the observation being made.

DR. SCOT-SKIRVING read some notes on a form of sore throat seen in anæmic persons, which paper was published in our last issue.

DR. CHAMBERS said that he could confirm all that Dr. Scot-Skirving had said, having frequently observed this condition of sore throat in anæmic girls.

DR. WORRALL said he regarded anæmia, and the form of sore throat just described, to be due to common causes, namely, struma and hot rooms. He did not think the mild local treatment mentioned by Dr. Scot-Skirving would be sufficient to cure the granular throat.

DR. BRADY referred to the writings of Mackenzie and a German author, who mention the connection described in the paper they had just heard. He also referred to certain neuroses of the throat seen in anæmic persons.

DR. KNAGGS also made a few remarks.

DR. SCOT-SKIRVING said that a great number of the patients he had seen with this ailment were not strumous. They did not suffer from granular pharyngitis, which was a very obstinate local malady. In the 1880 edition of Mackenzie's book, he had not noticed a description of the combination he had brought before their notice.

DR. TWYNAM exhibited and made some remarks upon a specimen of perforation of the vermiform appendix.

MEDICAL SECTION OF THE ROYAL SOCIETY OF N. S. WALES.

PRELIMINARY meeting of the Medical Section of the Royal Society, held in the Society's Rooms, Sydney, April 13; Dr. P. Sydney Jones in the chair. Members present—Dr. Manning, Sir Alfred Roberts, Drs. Knaggs, Goode, Roth, W. Chisholm, Warren, Hankins, Faithfull, Garrett, Worrall, Shewen, Lyden, Carruthers, Crago, Anderson Stuart, MacCormick, Jenkins.

It was proposed by Dr. Manning, seconded by Sir A. Roberts, and carried unanimously, that a recommendation be made to the Council of the Royal Society to have a list of the medical books and periodicals, the property of the Society, printed and circulated, together with the list of members.

A ballot was then taken for chairman for the ensuing year. Drs. Manning and Knaggs each receiving the same number of votes, but the former retired and Dr. Knaggs was duly elected chairman.

The following were elected committees:—Drs. W. Chisholm, Crago, E. Fairfax Ross, Sydney Jones, Hankins and Goode.

Drs. MacCormick and Jenkins were re-elected secretaries.

Meeting of the Medical Section of the Royal Society, held at Sydney, May 18. Dr. Knaggs in the chair. There were also present—Drs. Goode, Twynam, Chambers, Hankins, Faithfull, Worrall, Sydney Jones, W. Chisholm, Crago, Fairfax Ross, Lyden, Mander Jones, Jenkins, Sinclair (Gladesville), Shewen, Kendall, Martin, Marshall, Brady, Riddell (visitor).

DR. GOODE read notes on two cases of fracture of the skull—trephining—recovery. One of the patients exhibited.

DR. WORRALL then exhibited a fibro-myoma of the uterus, removed from a woman 66 years old. An interesting discussion then arose as to the best means of dilating the cervix uteri. Dr. Chambers condemned the indiscriminate use of such dangerous instruments as Sims and Hegar's dilator, and advocated the employment of laminaria tents in most cases.

DR. SYDNEY JONES was in favour of rapid dilatation by means of graduated bougies.

MR. HANKINS suggested strict antiseptic precautions, vaginal irrigation, and the disinfecting of the tents by sudden immersion in hot water.

DR. WORRALL replied. He was opposed to dilatation by tents, and thought that a small dilatation by means of a "Sims," followed by the introduction of a Barnes bag, would be the best mode of treatment.

The meeting ended at 9.45 p.m.

NEW ZEALAND MEDICAL ASSOCIATION.

THE Annual Conference of the members of the New Zealand Medical Association commenced on Wednesday, May 30, at the rooms of the Young Men's Christian Association, Wellesley-street, Auckland. About twenty members were present, the Southern Branches of the Association being represented by the following gentlemen:—Dr. de Zouche, Dunedin; Dr. Thomas, Christchurch; Dr. Fell and Dr. Mackenzie, Wellington. Dr. Dawson (Auckland), President of the Association, occupied the chair. Dr. Lindsay, of the Auckland Provincial Hospital, was appointed Secretary. The business was mainly formal. Some discussion took place as to whether the Press should be admitted, but it was decided that the meeting should be private, and that at the conclusion the Secretary should draw up a summary of any proceedings which were of general interest, for publication.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, JUNE 15, 1888.

EDITORIALS.

WANT OF PROVISION IN NEW SOUTH WALES FOR THE CARE OF THE WOUNDED IN CASE OF WAR.

WITH the cablegrams before us, which of late have so frequently appeared in the daily papers, relative to the imminence of war in Europe, in which Great Britain runs such risk of being involved, we feel it our duty to call attention to the absolute neglect by the Government of New South Wales to carry out the recommendations made by the Senior Medical Officer, Surgeon Major Williams, for the organisation of a proper military ambulance corps. This Officer, who during his visit to England passed through the military medical instruction course, and obtained a first-class certificate, has, we believe, done his best to bring about the necessary action, but has not, apparently, received that energetic support from the higher military executive authorities which is so essential to any action being taken by the existing Government. The Ministry have been forced into some sort of action as to military matters generally by the instinct of self-preservation, as their existence seemed to have a fair prospect of being destroyed if they shirked matters any longer, but the estimates and plans include nothing additional in matters medical. In Victoria, we believe a proper plan for the systematic care of the wounded, should the wave of war reach Australia, has been formulated for some years, and it is said to be so complete, that the very hospital furniture is ready stored for the conversion of public buildings, such as state school-houses, into temporary hospitals. As in New South Wales, equally with Victoria, the probable field of operations, can be pretty definitely fixed, some special inquiries should

be made to show what accommodation of a like kind would be available in the neighbourhood of Sydney and Newcastle. As it is, we have only six medical officers in the service, and no plan ready by which this very inadequate staff could be quickly increased. Should war break out before there has been time to so alter our present batteries as to make them in a degree protective to the men fighting the guns, our proportion of wounded is likely to be terribly large, and it is hard to see how they could be even temporarily treated with the present means at the disposal of the Medical Staff.

We know thoroughly that directly the necessity arises there will be no lack of volunteers from our professional ranks to render surgical assistance, but still this would not be so effective as the same assistance would be under proper organisation.

We have personal knowledge that all is not as it should be, for at an Easter encampment, being called on in the absence of the medical officers to render assistance to an accidentally wounded man, we found a hospital tent without appliances, and with anything but intelligent attendance.

THE ADDRESS OF THE VICE-PRESIDENT OF THE BOARD OF TECHNICAL EDUCATION OF NEW SOUTH WALES.

THE one paragraph of any interest to the medical profession in this long and discursive dissertation is that in which the speaker, after referring to the Medical School at the University, says, "Now, owing to my loving sympathy with learning, I shall be the last to object to this expenditure of public money; but, looking at it all as part of our fiscal policy, it is not quite easy at once to see why the general public should pay so many thousands a year to make our future professional men in medicine and law in the colony, to form part of the so-called upper classes, when our 'principles' will not allow us to pay just a little more in order to have our locomotives, say, made here, and when we are doing so very little, proportionately, to train and educate the artisans who make those locomotives, and who belong relatively to a much less wealthy and influential level in society than the members of the close and *protected* professions just referred to."

The gross inaccuracy exhibited by this official when describing medicine as a "*protected*" pro-

fession in New South Wales is, to say the least of it, amusing, in view of the recent revelations before and the report of the Select Committee of the Legislative Council on the law regulating medical practice in that colony.

We can only suppose that he goes about with his eyes shut and his ears closed, and that if he reads he does not understand. That this assertion was not made inadvertently is shown by the fact that in the printed issue of his address he has put the word "protected" as we reprint it—in italics. Throughout the address great animus is exhibited by him against medical men, which is but worthy of the person speaking, and the whole delectable production is thoroughly characteristic.

LETTERS TO THE EDITOR.

CASE OF LOCOMOTOR ATAXY OF OVER 10 YEARS' STANDING.

(To the Editor of the A. M. Gazette.)

SIR,—ABOUT 10 years ago A. H. noticed an itching round the ankles, which was followed by surface pains in the calves of the legs. This lasted 18 months, off and on. He then noticed that he could not run, and suffered acutely from lightning pains. At the end of three years he lost sensation in the sole of his foot; describes it as feeling as though he were walking on thick felt, and the difficulty in walking gradually increased.

When admitted to the hospital the flying pains had been absent five or six weeks. He could not step unassisted over any obstacle. On first applying the battery a slight contraction of the extensor muscles was discernable. Since his admission has had the battery daily (Faradic current) and half an hour's massage, also green iodide of mercury. Before the treatment commenced he could not stand on placing the heels together and closing his legs. Stamping gait very marked. Had syphilis 25 years ago; pins and needles nine years ago. Absence of patellar tendon reflex in both knees; paralysis of both arms; sense of coldness at the elbows, and over the ulnar nerve. Has four children, eldest 13 years, youngest 2 years and 4 months.

Measurement:—

	R. Thigh.	L. Thigh.	R. calf.	L. calf.
March 22—	15 in.	16 in.	12 in.	12 in.
March 28—	17 in.	17 in.	12½ in.	12½ in.

He left the hospital April 9, walking well.

STEPHEN FLOOD, M.D., F.R.C.S.I.
Toowoomba Hospital, Queensland, May 4, 1888.

MEDICAL ETIQUETTE.

(To the Editor of the A. M. Gazette.)

SIR,—I should be glad to have your opinion on the following:—A is in charge of a case; A is asked to allow B to be called in consultation; B refuses to come unless accompanied by C, who is his cousin, and to whom B has sold his practice and in which practice B has a pecuniary interest. A allows this; B asks A, in the patient's bedroom, in hearing of the patient and his wife and brother-in-law, what treatment he has adopted. On A mentioning one of the drugs used, B asks the quantity, and on being told says "Ah! a very large dose," in a manner calculated (even more than the words) to inspire the patient with alarm.

On adjourning to the dining-room, after the private consultation, B is informed by the patient's brother-in-law that two medical men from Sydney are to arrive by the mail train next morning; B then says that he and C will come to meet them in the morning.

At 6 o'clock in the morning the patient's brother called on A, with the two Sydney doctors, and hurried A off to see the patient at once. B and C never turned up.

The questions arise: 1. Was B justified in bringing his cousin into the consultation? 2. Was B justified in questioning A as to his treatment in the patient's presence, and in making the remark he did as to the quantity of the medicine (even if it were too large a dose which it was not—the Sydney doctors approving of it)? 3. Was B justified in proposing to continue himself and his cousin in attendance on the case, especially when the family had gone to the expense of summoning two eminent men from Sydney? 4. Was A to blame in not delaying the consultation, at 6 a.m. on a cold winter morning, until B could be summoned to attend—B already being aware of the hour at which the Sydney doctors were to arrive?

B has since refused to allow A to be called into consultation in a case of B's. A, on hearing of this, writes to B for an explanation in the matter. B replies in the following terms:—"I will briefly furnish you with my reasons for refusing to meet you in consultation although if all the circumstances attending our consulting in — case are fresh in your memory I would deem any explanation from me superfluous. I may then remind you that on that occasion after you, Dr. — and myself had consulted together we adjourned to the dining-room and there in company with Mr. — and other members of the family it was arranged that Dr. — and myself should meet you and the two medical men summoned from Sydney at Mr. —'s residence on the following day; to this proposal you offered no objection. At some inconvenience to myself I remained in town the chief part of the day to carry out this arrangement until I heard accidentally that the consultation had taken place and found that the arrangement made with Dr. — and myself had been quietly ignored! if you think that such treatment would not be resented you must consider that Dr. — and myself were both endowed with remarkably thick skins. It is no excuse for this act of rudeness to say that it was not required by the rules of Medical Etiquette that such meeting should take place, or that it was quite unnecessary, that is beside the question altogether, the point is, was not such an arrangement made with your knowledge and apparently with your consent, and was not that engagement ignored in a rude and insulting manner. The only course open to me to guard against the repetition of such treatment was to decline to meet you profes-

sionally and if this causes inconvenience to ourselves and the public, upon yourself rests the onus."

A, although amazed at B stating that himself and C would come on the following morning to meet the Sydney doctors, certainly made no objection; but that is a very different thing from arranging a consultation and afterwards ignoring it "in a rude and insulting manner." Even B in his "explanation" cannot go so far as to say more than that A "to this proposal offered no objection." Besides, the question arises, why did not B and C attend on the following morning as B. had said they would? Surely A is not to blame for their non-attendance.

As there does not seem to be much use in my trying to convince a man who can use such arguments (if they be arguments) as those contained in his letter, I should feel obliged by your giving your authoritative opinion on the foregoing.

I am, Sir, &c., M.D.

[The case, as stated by our correspondent, shows that A acted with all necessary consideration, which cannot be said for B and C. The conduct of B is much to be regretted, as showing an unworthy spirit when viewed from a professional standpoint.—ED. A. M. G.]

MEDICAL ETIQUETTE.

(To the Editor of the A. M. Gazette.)

DEAR SIR.—The following point of Medical Etiquette has arisen. I have commenced practice here, there being a medical man already resident in the place. Should I first call on him, or he on me? He is of opinion that I should call on him. Please advise.

I am, Sir, yours truly, NEW-CHUM MEDICO.

[The new-comer should certainly make the first call on the older resident.—ED. A. M. G.]

OBSTETRIC ENGAGEMENTS.

(To the Editor of the A. M. Gazette.)

SIR,—All is not gold that glitters," was the trite saying I remarked to a medical friend and fellow student of thirty years ago, as we sat the other evening, talking over old times, and enjoying the after dinner pipe. The above was my answer to his praise of a quiet, happy, and free bush life and practice, in comparison with that of the "jealous shoulder-struggle of a city existence," as he termed it. I agreed with him in the main, especially in a case like my own, where for many years my lot had been cast in places "up and down in the earth," having no true home, but where stern duty called, brooking no hesitation or reply, save that of prompt acquiescence. But, I remarked, "all is not gold that glitters"—per example: It had been the custom in these bush wilds, before I settled here, not to bespeak the doctor in confinement cases, but to engage some midwife or other, trusting in providence and send for the medico, should matters not jog along smoothly. To this custom I decidedly objected, and determined to put an end to, by giving notice to the public my determination not to guarantee my attendance unless previously engaged, as I could not see the equity of an arrangement like this, where the doctor, if called upon at all, had to undertake the grave responsibilities of a case, risking his reputation in endeavouring to rectify the blunders, or omissions of an ignorant "Betsy Prig," leaving out the grave moral and social issues at stake.

In one case, where the patient had been over forty-eight hours in labour, and I within call, I hesitated to attend, knowing the difficulties I should have to contend with, and which could have been avoided had I been summoned earlier. In reply to my demur, this "fac simile" of "Sairy Gamp" modestly informed me that she simply called me in to avoid any enquiry, also to be supplied with the all-powerful "certificate" in case the patient died, and, said she—"I am afraid, doctor," she's "booked." Thanks, however, to kind providence, and an excellent constitution, "the booking was yet delayed." After this example, and a few others of a similar nature, I felt bound in justice to myself as well as to those needing relief, to adopt the practice of a loved mentor, whose light shone amongst the rough, but honest people of the Yorkshire moors, who is now at rest, reaping the rewards of his earthly labours. Here is the plan:—

I expect to be engaged not less than a month previous to the time expected, and at the time my patient pays me a retainer of one guinea, which I allow for when the case is concluded, and the settlement follows. Should my services not be required, and the case does not demand my attendance, the patient forfeits her guinea. Under the old system, the rule was to be engaged, but no retaining fee paid, and scarcely ever to be sent for, and upon meeting the patient or some of her friends a long time afterwards, to be quietly told, "Oh! doctor, the case went off beautifully, and we did not need you, many thanks doctor." Now Sir, I am very loath to fill your valuable columns with unworthy material, but for the sake of my younger brethren who may settle in the far bush, I crave your indulgence, if perchance they may be saved from the many tricks that have been played upon

Yours faithfully,

TOUJOURS PRET.

DIPHTHERIA.

(To the Editor of the A. M. Gazette.)

SIR,—I read with much interest Dr. G. R. Eakins' useful article on "The successful treatment of Diphtheria," which appeared in the May number of the *Medical Gazette*. In a very fatal epidemic of diphtheria, which occurred at Queanbeyan in 1879, my uncle, Dr. Andrew Morton, had uniform success from a somewhat similar system of treatment. He applied locally equal parts of strong solution of perchloride of iron and glycerine twice a day, until the membrane began to disappear, when the application was weakened to one of perchloride to three of glycerine. Internally gave a mixture containing perchloride of iron, chlorate of potash, and glycerine. Nutritious slop diet and stimulants. Before he used the above method nearly every case ended fatally.

I, myself, have successfully treated several severe cases on these lines—one recently, in which there was much prostration, and the soft palate, uvula, tonsils, and pharynx covered with a thick, buff-coloured, foul-smelling membrane.

Dr. Eakins' suggestion in performing tracheotomy to remove an elliptical portion of the trachea, though answering for the time, would, if adopted, result in permanent narrowing of the tube from cicatricial contraction. I am, &c.,

WILLIAM J. MORTON, L.R.C.P., L.R.C.S. Edin.

Queanbeyan, N.S.W., May 18, 1888.

EUPHORBIA DRUMMONDII.

(To the Editor of the A. M. Gazette.)

SIR,—Mr. Fletcher, butcher, &c., of Donald (Vic.), informed me that of a flock of sheep in poor condition arriving from Adelaide, 10 died, and some were invalided after eating the weed. Sheep fell down, gave a few kicks and died soon, presenting symptoms of strychnia poisoning he thought! They were hoven, he said, for those that died appeared to be in the best condition. P.M.—the liver was pale, so was stomach. Stomach contained slimy substance and undigested plant. They were opened in order to find fluke, but none appeared. A squatter in the same district lost 150; no reliable information could be obtained. A farmer in the Laen district (some miles from Donald) says his sheep and horses eat it and like it. They have abundance of feed and water.

What about Drumme? With the small supply of impure stuff—impure on account of unfortunate circumstances in manufacture, &c.—at my disposal, I have additional notes to give. With a rectified spirit solution, a young man's toothache gave way. In cases of stomach pain and tenderness, after giving a few drops S.V.R. sol. in water, both the pain and tenderness disappeared. In case of asthma, in which smoking *Datura Tatula* for two weeks gave little relief, even though bromide of soda was given in quantity daily, a few drops in water soon gave relief on more than one occasion. There was stomach tenderness which also soon disappeared. He could lie flat in bed for the first time, although the bromide and chloral $\bar{a} \bar{a} \bar{a}$ it failed a few days previously, and bromide of soda had been given continuously for some time.

There is a slight amount of common salt in my S.V.R. solution, owing to faulty manufacture. No doubt the plant and product will be thoroughly investigated, so I refrain from comment.

JOHN REID, M.A., M.D.

143 Collins Street E., Melbourne, May 31, 1888.

SYDNEY UNIVERSITY MEDICAL SOCIETY.

THE Annual General Meeting of the above Society was held in the Clinical Theatre, Prince Alfred Hospital, Sydney, on Friday evening, March 23. The Hon. President, Dr. Graham, in the chair. The Secretary's Report was read and adopted. It showed that a full number of meetings were held last year, and some eight papers read. The Treasurer's Balance Sheet showed a credit balance. The election of office-bearers for the present year resulted as follows:—Hon. President, Dr. P. Bancroft; Ordinary President, H. V. Hinder; Vice-Presidents, L. Neill, B.A., and A. G. Mills; Hon. Secretary, Cecil Purser, B.A.; Hon. Treasurer, Leslie Hollis; Librarian, R. J. Millard.

Council—J. Hester, C. G. Wilson, G. H. Abbott, B.A., R. Dick.

A paper on "Homœopathy" was read by Mr. MacKenzie, and proved to be very interesting.

The second meeting for this season was held in the Clinical Theatre, on Friday Evening, April 27; Mr. Hinder occupied the chair. A large number of members were present, and also several visitors, including Sir Alfred Roberts, Dr. Goode, and Dr. Kinross.

An excellent paper, under the title of "Some Problems of Life and Mind," was read by Dr. J. T. Wilson, and an animated discussion ensued.

REVIEW.

A TEXT BOOK OF PHARMACOLOGY, THERAPEUTICS, AND MATERIA MEDICA.

BY T. LAUDER BRUNTON, M.D., D.Sc., F.R.S., &c., &c., &c. 3RD EDITION. MACMILLAN & Co., 1887.

THE date of the first edition is March, 1885, that of the third March, 1887, and it is a work of some twelve hundred pages. When a book of such magnitude has a demand so great in these critical days, and when there are so many books, it surely indicates that there is something in the work; and so there is. We have no hesitation in calling it an epoch-marking work. Its earlier editions were hailed with delight by all who read them, as giving the completest survey of rational therapeutics that had ever appeared, and this, the last edition, fully maintains the reputation of its predecessors. As many improvements as could reasonably be expected in the time have been made, and a preface is added, in which the Hahnemannian system and its votaries are referred to in very proper terms. Dr. Brunton gives to homœopathy all it can claim when he says, "Hahnemann also did good, and the system which he founded has done great service, by teaching the curative power of unaided nature, the use of diet and regimen in treating disease, and the more than inutility, the actual hurtfulness, of powerful drugs in many instances."

"It is not the use of a single drug at a time, of a small dose, of a globule, nor even, as we have already seen, of a drug which may produce symptoms similar to those of the disease, that constitutes homœopathy. The essence of homœopathy as established by Hahnemann, lies in the infinitesimal dose and the universal application of the rule *similia similibus curantur*. But the infinitesimal doses are so absurd that I believe they have been discarded by many homœopaths. To such men all that remains of homœopathy is the universality of the rule *similia similibus curantur*, and the only difference between them and rational practitioners lies in the fact that the latter regard the rule as only of partial application. At first sight this difference may seem to be only slight, but it is not so in reality; for while the rational practitioner, refusing to be bound by any 'pathy,' whether it be allopathy, antipathy, or homœopathy, seeks to trace each symptom back to the pathological change which caused it, and, by a knowledge of the action of drugs on each tissue and organ of the body, to counteract these pathological changes; the homœopath professes to be in

possession of a rule which will enable him to select the proper remedy in each case by a consideration of the symptoms, without reference to the pathological condition. He may thus dispense with anatomy, physiology, pathology and pharmacology. All that is necessary is a list of morbid symptoms on the one hand, and a list of the symptoms produced in healthy men by various drugs on the other."

"It is the falsity of the claim which homœopathy makes to be in possession, if not of the universal panacea, at least of the only true rule of practice, that makes homœopathy a system of quackery; yet this arrogant claim constitutes the essence of the system, and the man who, leaving Hahnemann and going back to Hippocrates, regards the rule *similia similibus curantur* as only of partial and not of universal application, has no longer any right to call himself a homœopath."

"Yet we hear some leading homœopaths say, 'We do not claim any exclusiveness for our method,' and then complain that they are excommunicated by the medical profession. If they have renounced the errors of Hahnemann's system, they ought not to retain its name, but frankly acknowledge their error and return to rational medicine, of which Hippocrates is regarded as the father. As a medical man is bound to do his utmost for the good of his patient, it is obvious that, although he may employ baths or packs as a mode of treatment, he cannot, without becoming untrue to his profession, throw aside all other means of treatment and become a hydropath; nor can he consult on equal terms with those who, either through ignorance or wilful blindness, deny the use of other means of cure and limit themselves to the application of water. What is true of hydropathy is true of homœopathy. I dislike controversy extremely, and should not have taken up so much of the preface with controversial matter had I not been forced to defend myself by the attacks which certain homœopaths have made upon me."

After quoting these paragraphs it will come as a surprise to many, and to none more than to Dr. Brunton, that here (in Sydney) a votary of Hahnemann claimed him in the public prints as a supporter of the Hahnemannian doctrine.

The first part of the book is given to "General Pharmacology and Therapeutics," in which are discussed the general relations between the organism and substances affecting it; the circumstances which affect the action of drugs on the organism; the action of drugs on protoplasm, blood, low organisms, invertebrata, muscle, nerve, spinal cord, brain, organs of spinal sense, respiration, circulation, the surface of the body, digestive system, tissue change, excretion, and the generative

system. Then follow chapters on the method of administering drugs, on antidotes, on the antagonism of drugs, and on dosage. The second part describes the various pharmaceutical preparations, and Part III takes up in detail the various items of the *Materia Medica*, and deals with each in the most careful and scientific manner.

A by no means unimportant part of the work are the indices—general, of diseases and remedies, and bibliographical.

We have no hesitation in saying that every medical man who is in earnest about his work should have and should study the book.* There is no other quite like it in any language. The introduction contains some so exceedingly pertinent remarks that we have no hesitation in quoting several paragraphs *in extenso*.

"By pharmacology we mean a knowledge of the mode of action of drugs upon the body generally, and upon its various parts. It is of comparatively recent growth, but is now one of the most important subdivisions of *materia medica*."

"Rational therapeutics consists in the administration of a drug because we know the pathological conditions occurring in the disease, and know also that the pharmacological action of the drug is such as to render it probable that it will remove or counteract these conditions."

"Rational therapeutics is the highest branch of medicine. Its advance is necessarily slow, because it is based upon pathology on the one hand and pharmacology on the other, and both of these rest upon physiology, which in its turn rests upon physics and chemistry. It is only with the development of the fundamental sciences that those which rest upon them can grow; and when we consider that chemistry as a science is not much more than a hundred years old, and when we see the advances it has already made, we cannot but be hopeful for the future of therapeutics."

"Occasionally we hear the question asked, 'What is the use of knowing the actions of all sorts of drugs upon the different parts of the animal body, and what is the use of knowing the alterations in the muscles, vessels, or nerves which occur under pathological conditions, seeing that in many instances such a knowledge cannot be utilised for the treatment of disease?' As well might we ask, on seeing a half-built bridge, 'What is the use of laying the foundations and building the piers, seeing no one can walk across from one end to the other.'"

"As an example of rational therapeutics, we may take the use of nitrite of amyl in certain

*The book can be obtained from Mr. Bruock, Medical Bookseller, in Sydney. Price 21s., postage 1s. 6d.

forms of angina pectoris. The obvious symptoms in this disease are intense pain in the region of the heart, and fear of impending death. Sphygmographic tracings of the pulse taken during this condition show that the tension within the heart and vessels begins to increase as the pain comes on, and reaches such a height that the heart can barely empty itself. Observations on animals have shown that nitrite of amyl lessens the tension of the blood in the vessels; and we therefore give it in angina pectoris with the expectation that it will diminish the tension and remove the pain, and we find that it succeeds."

"But this example shows us only the first stage of rational therapeutics. We have removed by a remedy the pathological condition which immediately gives rise to the pain and danger of the patient, but the antecedent alterations of the heart, blood vessels, and nervous system, which led to the occurrence of the pain are unaltered by the remedy. In order that our therapeutics should be completely successful, we must seek still further for something which will restore the circulation and nervous system to its normal condition and bring the patient back to a state of perfect health."

"Sometimes we are able to do this. For example, we occasionally meet with a kind of pain in the cardiac region which closely resembles angina pectoris, and is probably a form of it. Acting on the general principle that pain is due to irritation somewhere, though not necessarily at the place where the pain is felt, we seek for the irritant. We find swelling and tenderness over the sternum at the junction of the manubrium and the body, and we look upon this as the irritant which is exciting the cardiac pains. Judging this swelling to be syphilitic, we give iodide of potassium; the swelling subsides, and the angina-like pain completely disappears."

"But sometimes it is impossible to remove the cause of the disease, and all that we can do is to alleviate symptoms. The organic changes which have occurred in the course of the disease may be so great that we can hardly hope that any remedy will ever be discovered sufficiently powerful to remove them. We must therefore try to prevent them."

"Preventive medicine or prophylaxis is daily becoming more important, and, possibly, before the end of this century, medical men will be employed more to prevent people from becoming ill than to cure them when disease has become fairly established."

"This may at least be the case in regard to the contagious and infectious diseases, which attack people as it were by accident, and are totally unconnected with their ordinary work or

pleasure. It is too much to hope that other diseases which depend upon hereditary tendencies, over-work, or over-indulgence, will disappear, for there can be little doubt that men in the future will, as in the past, knowingly sacrifice, not only their health, but their life, to ambition, duty, or pleasure."

"Pharmacology has made such rapid advances of late years, that it is exceedingly difficult for many men who are engaged in practice to understand thoroughly either the methods by which it is studied, or its results. Many students also, although they may be able to pass a good examination in physiology, find it difficult to apply their physiological knowledge to pharmacology; and therefore, in discussing the action of drugs upon the various functions of the body, I have sometimes entered more fully into the physiology of those functions than may seem at all either necessary or advisable."

To our thinking it is just this account of the physiology of a system, in so far as it concerns the subject at the time, which constitutes much of the value of the book to the general practitioner, who is not often able and willing to read up text books, &c., along with a book on therapeutics. Dr. Brunton's physiological chapters are excellent, and give not only the facts, but often also the methods by which these have been attained, so that the book may be regarded as fairly complete in itself.

The first section of the body of the work opens with an account of the present state of our knowledge of the nature of the elements and of their compounds, and of the relationship between their physico-chemical characters and their physiological actions. The classification of the elements in "natural orders" so to speak, has been largely due to Mendelejeff, who has given convincing proof of the value of classification, "by not only predicting the existence of an unknown element, but actually describing its physical characters and chemical reactions, a prediction, the correctness of which was proved by the discovery of gallium, and by the agreement of its characters and reactions with those which Mendelejeff had foretold." "And this fact is not interesting to chemists only but also to pharmacologists. For the great object of pharmacology is to obtain such a knowledge of the relations between the physical and chemical characters of bodies and their action upon the living organism, that we may be able to predict their action with certainty, and to know the modifications, which alterations in their physical and chemical characters will produce on their physiological action."

"Mendelejeff's present classification is imperfect, because we find that by it the members of some

natural groups, such as those of the earthy metals, are separated from one another, although they agree in their chemical properties."

"We find also that metals having similar pharmacological actions, as copper, zinc, and silver, do not fall naturally together in this arrangement. But, on the other hand, we find also by this classification, elements are brought together which do not at first seem to have any resemblance to each other, and are yet found by recent investigations to have a physiological connection. Thus mercury and calcium do not appear to resemble one another, yet Dewar has shown that, in acute poisoning by mercury, the calcareous matter disappears from the bones, and in the process of elimination by the kidneys produces calcification of these organs."

"*Selective Action of Drugs*.—Drugs sometimes seem to affect only one part of the body and to leave the other organs unaffected. Although the drugs may be carried equally by the blood to every part of the body, they appear to combine with some and not with others. Many dye-stuffs will not attach themselves to cotton fabrics, but will do so readily to wool or silk; and we find that different tissues, and even different parts of the same tissue, have very unequal attractions for stains. Thus, some aniline colours will deeply stain a nucleus while leaving the cell in which it is contained entirely uncoloured. Although the different organs of the body contain many substances in common, yet their chemical composition varies within wide limits, and the products of the tissue-waste are also different. Even in the same organs the cells may have different properties, and even individual parts of the same cell may differ. Some have a reducing and others an oxidising action; some an alkaline, and others—as may be ascertained from their action on aniline colours—an acid reaction (p. 70). We would, therefore, expect that, just as tissues exert a selective action upon dye-stuffs, which we are able to see, they will also have a selective action on many organic substances, although this action may not be visible to our senses." In this connection it may be stated that Flesch has recently noted differences in the staining of nerve ganglion cells, which differences are thought to indicate differences of function.

When we read the foregoing paragraph we were reminded of the brilliant speech of Professor Huxley at the London International Medical Congress, in 1881, in which he spoke of "The connection of the biological sciences with medicine." Towards the end he said, "It appears to me that there is no more hopeful indication of the progress of medicine towards the ideal of Descartes (which he had referred to) than is to be

derived from a comparison of the state of pharmacology, at the present day, with that which existed forty years ago. If we consider the knowledge positively acquired in this short time, of the *modus operandi* of urari, of atropia, of physostigmin, of veratria, of casca, of strychnia, of bromide of potassium, of phosphorus, there surely can be no ground for doubting that, sooner or later, the pharmacologist will supply the physician with the means of affecting, in any desired sense, the functions of any physiological element of the body. It will, in short, become possible to introduce into the economy a molecular mechanism which, like a very cunningly contrived torpedo, shall find its way to some particular group of living elements, and cause an explosion among them, leaving the rest untouched." The progress of pharmacology during the seven years that have passed away since Huxley spoke, has fully justified his words, for during no previous period have so many substances been studied, and so much real work of value been done.

Although in reviewing we have selected for publication paragraphs which have seemed to us to indicate the scientific and hopeful side of the subject, the reader will be mistaken if he thinks the entire book is like this. On the contrary, the greatest part of the work deals with each item of the British and American pharmacopœias in detail, and shows what we do know about its *modus operandi*—if it has any, for are there not too many substances recommended for this or that, on very slender grounds. Still, the outcome of reading the book is to show that there are really many drugs with a fairly well ascertained action, and on the use of which the intelligent practitioner may rely. But it is only by the intelligent, rational use of these drugs that any good is to be done. Their use in the blind way, that alas, is all too common, leads only to a succession of failures which in the end breaks down that faith in medicines with which most begin their practice. We do not mean that this loss of faith in medicines is altogether unwarranted, but what we do mean is that the reasonless prescribing of drugs leads almost of a surety to failure, which is often ascribed to the medicine, when it might, with greater propriety, be attributed to the man who prescribed it.

A. STUART.

WANTED TO PURCHASE.—A GOOD PRACTICE IN SYDNEY or SUBURBS; state amount of premium required, and other particulars. Partnership not objected to. Address—F.R.C.S., *Australasian Medical Gazette* Office, 35 Castlereagh-street, Sydney.

THE INSANE POPULATION OF NEW SOUTH WALES IN 1887.

DR. F. N. MANNING, Inspector-General of the Insane in New South Wales, has favoured us with his report for 1887. From it we learn that the number and distribution of the insane in the colony on December 31, 1887, were as follows:—At Gladesville, 778; at Parramatta (free), 969; at Parramatta (criminal), 62; at Callan Park, 668; at Newcastle, 240, and at the Licensed House, Cook's River, 104; or a total of 2,821. Of these, 1,735 were males, and 1,086 females. The number on December 31, 1886, was 2,717, so that the increase during the year was 104, and was made up of 91 males, and 13 females. The number absent on leave was 51, being one more than at the same date last year. As the population at the end of 1887 was, according to the estimate of the Government Statistician, 1,042,919, the proportion of insane to population was 1 in 369. The proportion is higher than last year, the increase in the general population being much smaller than usual, whilst the number of the insane increased at about the usual rate. As the idea is still current that the proportion of insane to population in this Colony is unduly large, and in excess of that in England, it may be advisable to point out, as has been done in former reports, that whilst the proportion here, as above stated, is 1 in 369, or 2·71 per thousand, the proportion in England on January 1, 1887, was 1 in 349, or 2·86 per thousand. It is probable that the misapprehension has partly arisen from the fact that in this Colony the insane are almost all maintained in Public Asylums provided for by votes of the Legislature, whilst in England even the Public Asylums are supported by county, city, or district rates, and of the 80,000 insane under official inspection, 7,500 are maintained in lunatic hospitals and licensed houses; nearly 12,000 of the more aged, feeble, helpless, and quiet are kept in the lunatic wards of poorhouses, and there are upwards of 5,000 paupers supported from the rates in private dwellings, so that in England the insane in the aggregate come but little under public notice. The rapid increase in the number of the insane in this Colony, and the constant need of new buildings in which to place them, has no doubt something to do with the misapprehension on this subject. The number of insane persons under care has more than doubled since the end of the year 1877, when it was 1,387 only; but it should be remembered that at the same date the general population was only 519,182, so that this has also more than doubled during the same period.

The number of patients admitted for the first time during the year was 481, fifty-one were re-admitted, and twenty-nine were transferred, so that the total number under care during the year was 3,278, viz., 1,995 males and 1,283 females. Of these, 214 recovered, 25 were relieved, 29 were transferred, 4 escaped and were not recaptured, and 185 died, leaving 2,821 under care on December 31, 1887; the average number resident during the year was 2,722. Of the 185 deaths, thirty-seven were due to old age, 29 to diseases of the brain, 18 to general paralysis, 17 to epilepsy, 16 to pulmonary consumption, 15 to maniacal exhaustion, 11 each to apoplexy and inflammation of the lungs. Of the 214 patients who recovered, 8 resided in the hospitals under one month, 44 from one to three months, 52 from three to six months, 43 from six to nine months, 22 from nine to twelve months, 31 from one to two years, and 7 from two to three years. As regards the ages of the 3,278 patients under care during 1887, three were from one to three years old, 19 from five to ten years, 48 from 10 to

15 years, 99 from 15 to 20 years, 519 from 20 to 30 years, 746 from 30 to 40 years, 833 from 40 to 50 years, 576 from 50 to 60 years, 298 from 60 to 70 years, 132 from 70 to 80 years, and 20 over 80 years of age. 1,768 patients were single, 969 married, 200 widowed, and 1 the condition of the remaining 331 could not be ascertained. In regard to the religious profession, 1,433 patients belonged to the Church of England, 1,232 were Roman Catholics, 4180 Presbyterians, 98 Wesleyans, 57 Lutherans, 7 Pagans, 14 Jews, etc. Respecting their nationality we find that 935 were natives of New South Wales, and 111 of the other colonies; 922 were born in Ireland, 801 in England, and 160 in Scotland; 81 were Germans, 19 French, and 78 Chinese.

THE total expenditure for the year was £89,213 17s. 9d., or £2,271 8s. 3d. less than during the year 1886, notwithstanding that the average number of patients resident was 76 more, so that 2,629 patients were maintained in 1887 for £2,271 8s. 3d. less than 2,553 patients cost in 1886. The average weekly cost per head at all the hospitals, without deducting collections, has been 11s. 11½d., as against 12s. 7½d. in 1886, and, after deducting collections, 10s. 6d. as against 11s. 1¼d. in 1886.

THE INSANE POPULATION OF NEW ZEALAND IN 1887.

DR. DUNCAN MACGREGOR, Inspector of the Lunatic Asylums in New Zealand, has sent us his report for 1887, from which we learn that on the 1st January, 1887, the number of registered lunatics in the colony was 1,613, viz., 1,009 males and 604 females. Those admitted for the first time during the year numbered 341 (males, 214, and females, 127); the re-admissions amounted to 75 (males, 41, and females, 34), making a total under care during the year of 2,029, viz., 1,264 males and 765 females. Of these, 181 (103 males and 78 females) recovered; 51 (males, 34, females, 17) were relieved; and 101 (males, 74, females, 27) died; consequently, there remained in the asylums on 31st December, 1887, 1,696 patients (viz., 1,053 males and 643 females), being an increase of 83 (males, 44, females, 39) over 31st December, 1886. The average number resident during the year was 1,647. The 1,696 patients remaining on 31st December, 1887, were distributed as follows:—At Seacliff (Dunedin), 501; at Auckland, 385; Christchurch, 349; Wellington, 230; Hokitika, 104; Nelson, 101; and at the Auburn Hall Private Asylum, 25.

The proportion of insane to the general population in the Australian Colonies and Great Britain is as follows:—New Zealand (including Maoris), 1 in every 381, or 2·63 per 1,000; New Zealand (excluding Maoris), 1 in every 360, or 2·78 per 1,000; Victoria, 1 in every 306, or 3·27 per 1,000; New South Wales, 1 in every 375, or 2·67 per 1,000; South Australia, 1 in every 439, or 2·28 per 1,000; Queensland, 1 in every 418, or 2·39 per 1,000; England and Wales, 1 in every 348, or 2·87 per 1,000; Scotland, 1 in every 420, or 2·38 per 1,000.

Of the 1,696 persons under care remaining on 31st December, 1887, 585 were born in England, 472 in Ireland, 282 in Scotland, 119 in New Zealand, 21 in Australia, 33 in Germany, 19 in Sweden, 16 in Italy, 14 in France, 13 in Denmark, 6 in Norway, 26 in China, and 20 were Maoris.

As regards their ages, we find that 13 were between 5 and 10 years old, 14 between 10 and 15 years, 43 between 15 and 20 years, 250 between 20 and 30 years, 460 between 30 and 40 years, 502 between 40 and 50 years, 275 between 50 and 60 years, 91 between 60 and

70 years, 26 between 70 and 80 years, and 5 between 80 and 90 years.

The causes of the 101 deaths which occurred during the year were as follows:—Senile decay, 13; epilepsy, 10; phthisis, 10; paralysis, 10; exhaustion, 9; pneumonia, 8; apoplexy, 7, etc.

Respecting the causes of insanity, 39 cases were ascribed to drink; 28 were hereditary; 19 congenital; 16 due to senile decay; epilepsy, 12; brain disease, 11; religion, 13; puerperal state, 12; paralysis, 12; solitude, 10; sunstroke, 7; recurrent mania, 9; injury to head, 7; domestic troubles, 7; climacteric, 8; childbirth, 6, etc., etc.

As regards the former occupation of the patients, it is stated that amongst the males there were 60 laborers, 28 farmers, 14 miners, 11 clerks, 10 carpenters, 10 seamen, 8 bootmakers, and 7 hotelkeepers; and amongst the females there were 24 servants, 5 dressmakers, and 95 followed domestic duties.

The total expenditure for the year was £45,898 18s. 5d., or an average of £26 8s. 4d. per patient, but the cost per head, less re-payment for maintenance, was £22 12s. 3d.

THE INTERCOLONIAL RABBIT COMMISSION.

THE Intercolonial Rabbit Commission met again on Wednesday, May 23, when they held their first sitting in Adelaide. There were present—Dr. Wilkinson and Mr. Quin, New South Wales; Professor Allen and Messrs. Lascelles and Pearson, Victoria; Dr. Stirling, South Australia; Dr. Bancroft, Queensland; Mr. Bell, New Zealand; Mr. Tabart, Tasmania. In the absence of Dr. MacLaurin, Dr. Stirling was elected chairman. Professor Watson, of the Adelaide University, was examined at great length concerning the disease known as rabbit scab (*sarcoptes cuniculi*) introduced by him from Germany. About the end of March, last year, he succeeded in obtaining from Germany six diseased rabbits, which he associated with a certain number of Australian rabbits. The latter contracted the disease and all died within six months, though the older and stronger rabbits lived longer than the younger ones. He considered it was beyond dispute that the rabbits had died of *sarcoptes*. Some 60 rabbits in all had died of the disease, but all did not show the scab. The success of the disease depended entirely on a moist state of the atmosphere, and the witness unreservedly admitted that in the dry parts of Australia the disease would have no value whatever. He denied that the *sarcoptes* was communicable to man or to domestic animals, and instanced as proofs that he had experimented on himself and on dogs and cats without any effect beyond slight irritation, but it is understood that the commission have received from a medical man near Benalla, in Victoria, evidence showing that sheep in that district have died from the true *sarcoptes*. The other witnesses examined were gentlemen owning extensive properties in South Australia, Victoria, New South Wales, and Queensland. All who had employed Professor Watson's disease pronounced it without any exception to have been ineffective, used either under natural or artificial conditions. In very wet seasons some rabbits had died from contact with infected animals, but in dry weather the rabbits thrived and remained perfectly healthy.

On Thursday, May 24, the members of the Commission made an examination of rabbits infected by Professor Watson with *sarcoptes cuniculi*, and afterwards left for Silvertown to examine Dr. Butcher, who gave important evidence, and much impressed the Commission with the effectiveness of the Tintinology disease.

THE MONTH.

NEW SOUTH WALES.

IN 1887 the Government Vaccinators in N. S. Wales vaccinated 3,045 persons, as compared with 1,763 in 1886, and 7,055 in 1884. During the last 27 years the number of births in the colony was 639,201, but only 238,474 persons were vaccinated by the Public Vaccinators.

At the Water Police Court, Sydney, on May 10, Dr. S. C. Watkins, of Manly, was charged at the instance of the Board of Health of New South Wales with having neglected to report a case of small-pox at Manly Beach. Dr. Watkins, who pleaded guilty, was fined £10, besides 12s. costs, and £5 5s. the expenses of the prosecution.

DR. G. P. M. WOODWARD, of the N.S.W. Railway Medical Board, is rendering good service in the introduction of ambulance instruction in the Railway Department. At an examination held towards the end of last month, 44 employees passed and were enrolled in the ambulance corps, the medical examiner (Dr. R. E. Roth) stating that some of the papers showed extraordinary skill and aptitude on the part of the men. Since the commencement of the classes 179 men have passed the usual examination and proved themselves competent to render skilful and effective aid in cases of accident.

A LADIES' SANITARY ASSOCIATION has been established in Sydney with the object of diffusing knowledge relative to matters pertaining to health, cleanliness in the home, the care of the sick, and the careful preparation of food, &c. In furtherance of these objects a course of lectures will be given during the winter months by medical men on various matters connected with hygiene, open to all non-members on payment of a nominal fee of five shillings for the course. The lectures have been arranged for the present winter, Drs. Renwick, Anderson Stuart, Scot-Skirving, W. C. Wilkinson and Eddington Jefferis having undertaken to act as lecturers.

DR. J. T. BURGOYNE, late of Moruya, has settled at Balmain, a suburb of Sydney, where he has been appointed one of the Medical Officers of the United Friendly Societies.

DR. J. DIAMOND, formerly of Mudgee and late of Paddington, has commenced practice at Campbelltown, 34 miles S.W. of Sydney.

DR. W. W. ELMSLIE has removed from Junee to Grenfell, where he has been elected Medical Officer of the local Hospital, out of eleven candidates.

DR. FIELDSTAD has removed from Wynyard-square to 173 Liverpool-street, Hyde Park, Sydney.

DR. B. KORFF, formerly of Adelaide, has succeeded to the practice of Dr. G. Cuscaden, at Urana, in a pastoral and agricultural district, 38 miles S. W. of Sydney.

DR. JAS. MACKY has removed from Blayney to Woolahra, a suburb of Sydney.

DR. L. D. PARRY, late of Hill End, has removed to Emmaville (Vegetable Creek), the centre of a rich tin-mining district, 447 miles N. of Sydney. Dr. Parry has been appointed Medical Officer of the local Hospital and the Miners' Association.

DR. H. J. H. SCOTT, the well-known cricketer, has commenced practice at Cordillera, near Tuena, the centre of an extensive silver-mining district, 200 miles S. of Sydney.

DR. C. G. THORP has settled at Mount Kembla, a coal-mining township, 5 miles from Wollongong.

DR. T. B. WALLEY, late of Narrabri, has settled at Tamworth, 251 miles N. of Sydney.

DR. R. W. YOUNG, late Assistant Resident Medical Officer at the Little Bay Coast Hospital, near Sydney, has commenced practice at Gundagai, where he has been appointed Medical Officer to the local hospital.

NEW ZEALAND.

THE Government are being moved in the direction of considering the advisableness of amending the Medical Practitioners Act, in the direction of subjecting to a penalty all persons who, under the designation of "faith healers," extract fees from many weak-minded or ignorant invalids.

MRS. FREESTONE, of Eden Crescent, has brought an action against Dr. Kenderdine, of Auckland, for £400 damages for the loss of her left eye through alleged maltreatment.

DR. L'ESTRANGE IDELL, a new arrival, has settled at Waipawa, the second township in importance in Hawke's Bay, 42 miles S.W. of Napier.

QUEENSLAND.

In the *Government Gazette*, of May 3, the Queensland Medical Board notifies that—"It having been ascertained that one Richard Thomas Freeman, of Croydon, has obtained his registration from this Board by fraudulent means, the said registration is hereby cancelled, and his name erased from the medical list of duly qualified medical practitioners of this colony."

DR. MAY, of Bundaberg, has brought under the notice of Mr. Pugh, the local police magistrate, a case which both he and Dr. Thomas believe to be leprosy. The patient is a Kanaka, who states that he is a native of the island of Apia, and has been in Queensland thirteen years. The disease is at present confined to his left forearm and hand. Mr. Pugh suggests that it would be very much more satisfactory to the medical men, and also to the general public, if such cases were examined and reported upon by an expert in this disease.

A SURGEON is required for the Springsure Hospital, salary £250 per annum (including allowance of £20 for use of instruments). Private practice to the extent of £250 per annum will be guaranteed by the residents of the town and district. A very comfortable and suitable residence can be obtained—rent £40 per annum. Applications, with testimonials, will be received up to July 4, by the Secretary, Mr. W. A. Leigh.

DR. J. BOOTH has removed from Gympie to Thornborough, the centre of the Hodgkinson gold field, 1,100 miles N.W. of Brisbane.

DR. G. COMYN, late of Roma, has removed to Red Hill, a suburb of Brisbane.

DR. FRANCIS PAIN has removed from Pittsworth to Allora, the centre of the rich farming district of the Eastern Downs, 156 miles S.W. of Brisbane.

DR. A. SUTTON has commenced practice at Beenleigh, in a sugar-growing district, 24 miles S. of Brisbane.

DR. W. F. THURSTON, late of Rockhampton, has resigned his appointment as a Surgeon in the Queensland Defence Force.

DR. F. H. V. VOSS has been appointed to be Health and Medical Officer at Rockhampton, and also Assis-

tant Immigration Agent and a Member of the Immigration Board at that place, in the room of W. F. Thurston, M.R.C.S., resigned.

DR. FRANK WINTER, a new arrival, has temporarily settled at Clermont, in the pastoral and copper-mining district of Peak Downs, 575 miles N.W. of Brisbane.

SOUTH AUSTRALIA.

THE members of Mount Barker Branch of St. John's Ambulance Association have been examined by Dr. Henderson, of Adelaide, who, in his report, speaks in complimentary terms of the capabilities of the candidates prepared by Dr. Bickle. The Chief Secretary distributed the certificates of the Association on June 1 to the successful members—ten ladies and six gentlemen.

DR. R. H. MARTEN has been elected Honorary Assistant Surgeon to the Adelaide Hospital.

TASMANIA.

LOCAL Boards of Health have been appointed for the districts of Queenborough, Torquay with Formby, Newtown, Ulverstone, Brothers' Home, Burnie, West Tamar, Boobyalla, and Kingston.

VICTORIA.

THE Council of the next Intercolonial Medical Congress of Australasia, to be held in Melbourne in January, 1889, have elected the Hon. J. M. Creed, Editor of the *A. M. Gazette*, one of the Vice-Presidents of the Congress, the Hon. Dr. Mackellar, of Sydney, President of the section of "Medicine," Professor Anderson Stuart, of the Sydney University, President of the section of "Anatomy and Physiology," and Dr. H. N. MacLaurin, President of the N. S. Wales Board of Health, President of the section of "State Medicine and Public Health."

THE following gentlemen have been appointed by the Government for the term of three years as the Veterinary Board of Victoria, viz.:—Messrs. J. Aked, G. Snowball, H. Wragge, A. Sharp, Graham Mitchell, C. Marson, and W. T. Kendall, Members R.C.V.S., Mr. Aked to be the President of the said Board.

SINCE December 1 of last year to the middle of May, 1,303 cases of typhoid have been reported to the Central Board of Health, of which 293 proved fatal. During the same period there were 209 cases of diphtheria, 104 having proved fatal.

FROM the Annual Report of the Victorian centre of the St. John Ambulance Association, we learn that the number of pupils instructed during the past year was 913, and of those 442 received certificates of competency. The total number instructed during the past three years was 1,260 women and 1,007 men.

AT a meeting of the Central Board of Health, held on May 14, a letter was received from Mohabeer Sing, an Indian doctor, through Mr. J. A. Wallace, M.L.C., stating that he would undertake to cure the three or four Chinese lepers in the colony, provided he got £4 a week for a year. Towards that sum, Mr. Wallace, who, it was stated, had taken a good deal of interest in the matter, offered to contribute £1 a week. Mr. Blackett thought the best thing Mohabeer Sing could do was to return to his own country or to go to China, where there were plenty of lepers, and where the

doctor would have a splendid opportunity of demonstrating his powers. In any case the Board could do nothing in the matter. Another person offering, in the hope of obtaining a reward, a specific which, he said, was a certain cure for diphtheria, was referred to the Medical Society.

ON Friday night, May 11, a fire broke out in the Ararat Lunatic Asylum, in that portion of the building occupied by refractory patients. The latter were safely got out and placed in custody in another part of the asylum, separated from the building on fire. The flames were subdued before much damage was done.

A SUBSCRIPTION is being raised in Melbourne among the friends of the late Dr. W. H. Campbell, for the purpose of erecting a suitable monument over the grave of the deceased.

A COURSE of lectures on midwifery and elementary general nursing is now being given to the nurses and pupil nurses of the Melbourne Women's Hospital, by Dr. Eugene Anderson, Resident Medical Officer. The first lecture was given on May 25, and the second on May 31.

DR. P. H. MACGILLIVRAY has been elected President, and Dr. A. Colquhoun Vice-president of the Science Society at Sandhurst.

DR. T. M. AUSTIN has removed from Mitiamo to Kerang, in an agricultural and pastoral district, 195 miles N.W. of Melbourne.

DR. ANTHONY C. BROWNLESS, Chancellor of the Melbourne University, has been appointed a Companion of the Order of St. Michael and St. George.

DR. C. E. GOODALL has commenced practice at Balaclava, a suburb of Melbourne.

DR. W. A. HARRISON, late of Dunedin (N.Z.) has settled at Hawthorn, a fashionable suburb of Melbourne.

DR. R. L. MCADAM has commenced practice at Swan Hill, on the River Murray, in a pastoral district, 231 miles N.W. of Melbourne.

DR. J. H. MACKENZIE has removed from Tallangatta to Wodonga.

MR. JOHN MACNAUGHT, L. et L. Mid. R.C.P. et R.C.S. Edin., 1877, Public Vaccinator and Health Officer at Winchelsea, is dead.

DR. D. L. MILLER, of Warrnambool, has gone home for a trip; during his absence Dr. Vandeleur Kelly will carry on his practice.

DR. F. J. NEWMAN has resigned his position as Surgeon of the Geelong Hospital. The Committee accepted his resignation with regret, and decided to present Dr. Newman with a testimonial before he leaves the hospital.

DR. C. J. PARKINSON, late Senior House Surgeon at the Hobart General Hospital, has commenced practice at Malvern, near Melbourne.

DR. C. H. WATERS, a new arrival, has commenced practice at Rosedale, in an agricultural and pastoral district, 111 miles E. of Melbourne.

DR. R. T. WESTBROOK has succeeded to the practice of Dr. A. R. Stacpoole at Numurkah, in an agricultural district, 133 miles N. of Melbourne. Dr. Stacpoole, we understand, intends to retire from practice and to take up his residence at Hawthorne, a favourite suburb of Melbourne.

HOSPITAL INTELLIGENCE.

THE Adelaide Hospital Board have the intention to appoint a lady as a Member of the Board, to act *ex officio* as a member of the House Committee, as there were many things which came properly within a woman's duty, where her assistance and judgment would be a benefit to such an institution.

IN reply to a request of the Board of Management of the Auckland (N.Z.) Provincial Hospital that the Medical Staff would give their opinions as to whether any danger would arise were they to attend to the scarlet fever cases, Dr. MacMullen forwarded a report stating that it was the strong opinion of the majority of the Medical Staff that there would be serious risks to the surgical cases in their so doing. Dr. Erson wrote offering to attend to the cases in the scarlatina ward. It was decided "That Dr. Erson's offer be accepted, subject to the approval of the Honorary Staff."

AT a special meeting of the Committee of the Brisbane Hospital, held on the 8th May, leave of absence for twelve months was unanimously granted to Dr. E. S. Jackson, who has now been Medical Superintendent of the hospital for five years, during which time he has been very hard worked, and has had only one short leave of absence. During Dr. Jackson's absence, Dr. Hare, Resident Medical Officer, will perform the duties of Medical Superintendent, and Dr. Henry T. Forbes has been appointed to assist him.

THE sum of £1,000 has been placed upon the Estimates by the Government for enlarging the Victoria Hospital at Barcaldine (Qu.), the present terminus of the Great Central Railway.

IT is proposed to erect a new hospital at Gympie (Q), after the plans of the Charters Towers Hospital. Up to the present time subscriptions amounting to upwards of £2,100 have been received towards the building fund.

THE Chinese residents at Port Darwin (N.T.), have subscribed over £500 towards a Hospital for Chinese, and now want the Government to give the requisite land and supplement the subscriptions.

THE Directors of the Sydney Hospital have decided to appoint a Resident Medical Superintendent of the Institution as soon as practicable.

THE total number of patients admitted to the Coast Hospital at Little Bay, near Sydney, during the past year was 1,726, viz., 1,235 males and 491 females. The average daily number of inmates was 198.5, an increase over the previous year of 52.3. The mortality was 9.21 per cent.

THE new hospital at Molong (N. S. Wales) will be opened on September 1.

AT a meeting of the Committee of Management of the Melbourne Women's Hospital, held on May 18, a letter was read from those members of the Honorary Medical Staff who attended to the infirmary department of the hospital, claiming a portion of the fees paid by medical students visiting the institution. It was stated that there were only three students who paid any fees for instruction, and these were in the midwifery department of the hospital, and therefore the committee failed to see how the Honorary Medical Officers referred to could expect to receive a part of those fees. A number of students attending the University, who were in their fourth and fifth year of medicine, it was said, visited the institution, and gained experience in the infirmary, but they paid no fees for that privilege. It was decided

to reply to the letter, and draw attention to the regulation recently passed by the committee directing all fees to go to the benefit of the funds of the hospital, and to intimate that until that rule was rescinded the request for a portion of the fees could not be complied with.

THE cost of the new wing of the Melbourne Women's Hospital, including the furnishing of it, will be £15,885 when finished.

A TABLET has been placed on the wall at the entrance to the new wing of the Melbourne Women's Hospital, dedicating the building to Miss Genevieve Ward, and describing the circumstances under which she contributed £2,500 towards its erection, and another giving the Chinese credit for having materially assisted at a bazaar which realised £1,000 in aid of the funds of the hospital.

IN connection with the alleged cases of improprieties between nurses and students at the Melbourne Women's Hospital, the sub-committee of investigation have found that nothing more than "larking" had been indulged in. The head nurse was censured for laxity of supervision, and a month's notice given her.

IT is proposed to erect an additional ward to the Geelong (Vic.) Hospital, to be chiefly devoted to the treatment of children's cases.

MR. M. H. DAVIES, Speaker of the Victorian Legislative Assembly, has forwarded to the Committee of the Austin Hospital for Incurables near Melbourne, his cheque for £1,000 towards the proposed addition to the institution in the shape of a hospital for consumptives. This new hospital will be a separate institution from the present building, and the erection of a portion of it, probably the right wing, to accommodate 14 patients, and estimated to cost about £1,500, will be commenced forthwith.

UNIVERSITY INTELLIGENCE.

AT a meeting of the Council of the University of Melbourne, held on May 14, it was resolved on the motion of Mr. R. Murray Smith, "That no degree *ad eundem gradum* be conferred in medicine (or surgery) unless the diploma on which the applicant founds his claim for such degree or a state certificate, gives him authority to practise in the country where it was conferred." The motion, Mr. Smith said, was intended to guard against any possible evil effects which might flow from the recent admission of Dr. Henry, of the University of Würzburg, as being from a University that was "recognised by this University." It appeared that some of the European Universities in granting medical diplomas did not thereby give any authority to practise.

THE Council of the University of Melbourne, having decided to leave the selection of Clinical Lecturers and Tutors of each hospital to the respective medical committees, Dr. Embling, Chairman of the Hon. Medical Staff of the Alfred Hospital, has informed the Council that the following gentlemen have been selected for the positions, and will deliver clinical lectures during the present academical year on Tuesdays at 10 o'clock:—Medical—Drs. Embling, Jamieson, and Thomson. Surgical—Messrs. Cooke, Rudall, and Harricks. Dr. Maudsley, Hon. Pathologist, will demonstrate every week; and Drs. Cox, Travers, and Elsner, specialists, as necessity arises.

The subsidy of £500 per annum given by the Melbourne University towards clinical teaching has been apportioned as follows:—Melbourne Hospital, £400; Alfred Hospital, £100.

A LETTER has been addressed to the Senate of the University of Sydney by the hon. Secretary of the Prince Alfred Hospital, stating that the report of the combined Committees of the Senate and the Board of Directors, in reference to the appointment of certain Officers connected with the Medical School, was submitted to a Special Meeting of the Board of Directors of the hospital on May 16, and adopted. It was decided that a meeting of the conjoint Board, consisting of the Senate of the University and the Board of Directors of the Prince Alfred Hospital, should be called for the third Monday in June to confirm the report which had been adopted by the two bodies severally.

OBITUARY.

JOHN INNES DUNLOP

MR. JOHN INNES DUNLOP, M.B. et Ch.M., Glasg., 1883, died suddenly on April 16, at Red Hill, a suburb of Brisbane, where he had been practising for the last four months. The deceased was formerly Junior Assistant Medical Officer at the Joint Counties Asylum in Abergavenny, England, and afterwards, in 1886, he left for Fiji, where he spent 18 months as District Medical Officer; this appointment he resigned last November and came to Australia soon after. He was only 26 years old at the time of his death.

RICHARD GOLDSTONE.

MR. RICHARD GOLDSTONE, L.S.A. Lond., 1825; M.R.C.S. Eng., 1835, a colonist of 25 years' standing, died at his residence at Cheltenham, near Melbourne, on May 29, at the ripe age of 85 years.

LOUIS CONRAD JOCKEL.

MR. LOUIS CONRAD JOCKEL, L. et L. Mid. R.C.P. et R.C.S. Edin., 1874, Government Medical Officer and Vaccinator for the Richmond and Windsor districts, died at his residence at Richmond (N.S. Wales) on May 20, at the age of 37. The deceased gentlemen arrived in the colony in 1875, and has practised at Richmond ever since; he was formerly surgeon on board the R.M. steamer "Bowen."

EDMUND RAGHIB.

MR. EDMUND RAGHIB, M.R.C.S. Eng., 1885; L.S.A. Lond., 1884, died on April 11, at Mitiamo, Victoria, of consumption, at the early age of 26. The deceased was a native of Wandsworth, London, and arrived in Western Australia in 1886; he practised at Perth for about 18 months, and then, after travelling through New South Wales and Victoria for some time, he settled at Mitiamo only a few weeks ago.

Medical Books at PUBLISHED Prices.

MR. BRUCK, Medical Bookseller in Sydney, begs to inform the profession that he is selling all medical books at PUBLISHED prices. A list of some of the books in stock, with published prices attached, will appear in next issue.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Stace, Malcolm Vincent, L.R.C.P. Edin., 1879; L.R.C.S. Edin., 1879.
Weekes, Charles Jones, L.R.C.P. Lond., 1888; M.R.C.S. Eng., 1888.
Henry, Arthur Geddes, M.B. Sydney, 1888.
Stephens, Samuel, L.S.A. Lond., 1887; M.R.C.S. Eng., 1888.
Russell, Robert Usher, L.R.C.S. Irel., 1883; L.R.C.P. Edin., 1888.
Reading, Richard Fairfax, M.R.C.S. Eng., 1887; L.R.C.P. Lond., 1887.
Scott, Henry James Herbert, M.R.C.S. Eng., 1888; L.R.C.P. Lond., 1888.
Bacot, William Rickward, M.R.C.S. Eng., 1887.
Bennett, Thomas Charles, M.B. of M.S. Aberd., 1886.

NEW ZEALAND.

Isdell, L'Estrange, L.R.C.S. Irel.; L. of L. Mid. K.Q.C.P. Irel.
Gledden, Alfred Maitland, M.R.C.S. Eng.; L.R.C.P. Lond., 1886.

QUEENSLAND.

Jones, Walter William Stockton, L.R.C.S.I., 1881; L. of L. Mid. K.Q.C.P. Irel., 1881.
Forbes, Henry Farquharson, M.B. of Ch.M. Aberd., 1886.
Winter, Frank.

VICTORIA.

Maloney, William Robert Nuttall, M.R.C.S. Eng., 1885; L.S.A. Lond., 1885.
Harrison, William Atkinson, M.B. of Ch.M. Edin., 1880.
Thomas, John, L. of L. Mid. R.C.P. of R.C.S. Edin., 1886.
Cuscaden, George, L. of L. Mid. R.C.P. of R.C.S. Edin., 1880.
Waters, Clarence Henry, M.B. of Ch.M. Edin., 1886.
Howitt, Godfrey, M.B. of Ch.B. Melb., 1888.
Raghib, Edmund, L.S.A. Lond., 1884; M.R.C.S. Eng., 1886.
Kelly, Robert Vandeleur, L. of L. Mid. R.C.P. Edin., 1873; L. 1873, F. 1880, R.C.S. Edin.

Additional qualifications registered:—

McAdam, Robert L., Qual. State Med. Dubl., 1886.
Barrett, James W., Ch.M. Melb., 1888.
Praagst, Lionel F., Ch.B. Melb., 1888.
Fletcher, Arthur A., M.D. Melb., 1888.
Craig, Walter J., Ch.B. Melb., 1888.
Carney, John H., Ch.B. Melb., 1888.
Bartley, Joseph F., Ch.B. Melb., 1888.
Howard, George T., M.D. Melb., 1888.
Miller, Joseph J., Ch.B. Melb., 1888.

MEDICAL APPOINTMENTS.

Allan, William, M.B. of Ch.M. Edin., to be a Public Vaccinator for the districts of East and West Tairā, N.Z.
Austin, Thomas Mein, L.R.C.P. of R.C.S. Edin., to be Public Vaccinator at Kerang, Vic.
Booth, James, L.R.C.P., to be Government Medical Officer at Thornborough, Qu., vice Dr. C. D. G. Cole, resigned.
Chilton, Maurice Alfred, L.R.C.S. of R.C.P. Edin., to be Public Vaccinator for the district of Oponake, N.Z.
Diamond, James, M.D. of Ch.M. Glasg., to be Government Medical Officer and Vaccinator for the district of Campbelltown, N.S.W.
Hacon, Walter E., M.R.C.S. Eng., L.R.C.P. Lond., to be Honorary Physician to the Christchurch Hospital, N.Z.
Hewer, Henry John, M.B. of Ch.B. Melb., M.R.C.S. Eng., to be Government Medical Officer at Aramac, Qu.
Jameson, Adam, M.B. of Ch.M. Ed., to be Health Officer for the city of Perth, W.A.
Korff, Berthold, M.D. of Ch.D. Wurzb., to be Government Medical Officer and Vaccinator for the district of Urana, N.S.W., vice Dr. G. Cuscaden, resigned.
Lermite, Charles Gower, M.R.C.S.E., to be a Public Vaccinator in South Australia.
Liddle, Percy Herbert, M.B. Melb., to be Junior Deputy Medical Superintendent of the Beechworth Lunatic Asylum, Vic.
Marten, Robert Humphrey, M.B. Cantab., to be Public Vaccinator at Adelaide, S.A.
Mead, Rivis, M.B. of Ch.M. Ed., M.R.C.S.E., to be Health Officer for shire of Lowan, W.R., Vic., vice W. Cumming, M.D., resigned.

Mollison, Crawford Henry, M.B. of Ch.B. Melb., to be Demonstrator of Anatomy at the Melbourne University.
Paoli, Francesco, M.D. of Ch.D. Bologna, to be Government Medical Officer at Charters Towers, Qu., vice Dr. E. B. J. Mohs, resigned.
Rogers, Richard Sanders, M.B., to be Public Vaccinator for Port Wakefield, S.A.
Smith, Henry Lionel, L.R.C.S.I., L.K.Q.C.P. Irel., to be Health Officer at Albany, W.A.
Smith, William Beattie, F.R.C.S. Ed., L.R.C.P. Ed., to be Medical Superintendent of the Ararat Lunatic Asylum, Vic.
Sturdee, Alfred Hobart, M.R.C.S.E., to be Health Officer for shire of East Loddon, E.R., Vic., vice T. M. Austin, L.R.C.P., resigned.
Swift, Harry, M.D., to be Public Vaccinator at Adelaide, S.A.
Warren, Henry Guy Seymour, L.R.C.P. Lond., M.R.C.S.E., to be Visiting Surgeon to the Gaol at Dubbo, N.S.W.
Waters, Clarence Henry, M.B. of Ch.M. Edin., to be Officer of Health for the shire of Rosedale, Vic., vice Dr. G. A. Walpole, resigned.
Watt, George, M.B. of Ch.M. Aberd., to be Government Medical Officer and Vaccinator for the district of Obar, N.S.W., vice Dr. Newman, resigned.
Woods, William Cleaver, M.D. of Ch.M. Ed., of Albany, N.S.W., to be Public Vaccinator at Wedonga, Vic., vice Dr. F. Landvoigt, resigned.

BIRTHS, MARRIAGES, AND DEATHS.

* * * The charge for inserting announcements of Births, Marriages, and Deaths is 2s. 6d., which should be forwarded in stamps with the announcement.

BIRTHS.

ANDERSON.—On the 27th May, at Lismooney, Ootamundra, N.S.W., the wife of Dr. J. F. Anderson, of a daughter.
BALDWIN.—May 15, the wife of G. Pearce Baldwin, L.R.C.P., J.P., Neutral Bay, Sydney, of a daughter.
CLUBBE.—May 19, at Calioes, Randwick, Sydney, the wife of Dr. Charles P. B. Clubbe, of a daughter.
ECCLERS.—On the 26th May, at 105 Collins Street East, Melbourne, the wife of J. V. Eccles, M.D., of a daughter.
FLORANCE.—May 24, at Picton, N.S.W., the wife of Egbert Florance, M.D., of a son.
HOGG.—On the 19th April, at Goodna, Queensland, the wife of James Ballantine Hogg, L.R.C.P. & S., of a daughter.
JENKINS.—May 17, at 213 Macquarie Street, Sydney, the wife of Edwd. J. Jenkins, M.D., of a son.
MOORE.—At Liverpool Villa, Symonds Street, Auckland, N.Z., on May 8, the wife of Dr. J. M. Moore, of a son.
O'CONNELL.—On the 4th May, at Angus Street, Victoria Square, Adelaide, the wife of Dr. James O'Connell, of a son.
OWEN.—On the 10th May, at Brunswick Street, North Fitzroy, Melbourne, the wife of F. J. Owen, M.D.—a son.
PARKINSON.—On the 3rd June, at Hobart, the wife of C. J. Parkinson, M.B., Glenferrie-road, Malvern (Melbourne), of a daughter.
READ.—June 4, at Singleton, N.S.W., the wife of Dr. Richard Read, of a son.

MARRIAGES.

LOVE-DAVIDSON.—On the 8th May, at Christ Church, Milton, Brisbane, by the Rev. Manley Power, rector, Wilton Wood Russell Love, M.D., the eldest son of the late Rev. James Love, to Lucy, third daughter of William Montgomerie Davidson, Deputy Surveyor-General, Queensland.
ROBERTS-KING.—On the 1st June, at St. Saviour's Church, Melbourne, by the Rev. C. M. Yelland, Shirley Roberts, M.R.C.S., L.K.Q.C.P.I., of Avoca, to Violet Maud, daughter of the late Captain John Wingfield King, H.M. 5th Regiment, of Ballygrehan, Co. Sligo, Ireland.
SISCA-ANDERSON.—On the 16th inst., at Ballarat (Vic.), Natalie Sisca, M.D., of Mount Egerton, to Alicia Sarah Anderson, of Baling.
VAILE-ELMSLEY.—On May 11, at St. Sepulchre's Church, Auckland, N.Z., by the Rev. Archdeacon Dudley, Percy A., second son of J. R. Vaile, Esq., to Gertrude, youngest daughter of Joseph Elmsley, M.D., Otahuhu, N.Z.

DEATHS.

LAWRENCE.—At Halton House, Hurtle Square, Adelaide, Jack Lawrence, son of Dr. Lawrence, aged 6 years.
MORGAN.—May 20, at "St. Helens," Bowral, N. S. Wales, Frances Emma, daughter of Dr. A. B. Morgan, aged 17.

REPORTED MORTALITY FOR THE MONTH OF APRIL, 1888.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Group and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Cancer.	Child-bearing.
N. S. WALES.														
Sydney	132,846	360	180	72	3	1	4	...	10	16	12	17	6	1
Suburbs	215,849	853	369	195	9	1	12	...	18	24	38	12	10	2
*NEW ZEALAND.														
Auckland	35,965	76	33	19	...	...	...	1	2	7	1	2	1	...
Christchurch	16,217	26	17	6	...	...	2	...	...	1	1	1	...	...
Dunedin	24,334	38	17	1	...	...	...	...	...	1	1	2	1	...
Wellington	28,235	70	18	7	...	...	...	...	...	3	4	2	...	...
QUEENSLAND.														
Brisbane	51,689	207	81	34	}	...	8	...	6	21	13	8	2	...
Suburbs	21,960	106	45	34										
SOUTH AUSTRALIA.....	313,364	876	304	124	...	1	13	1	11	24	29	26	7	6
Adelaide	43,527	96	67	18	...	...	1	...	4	3	14	7	2	1
TASMANIA.														
Hobart	32,023	93	53	15	...	...	4	...	6	5	5	4	3	...
Launceston	20,079	64	40	8	...	...	1	...	5	1	4	3	1	1
Country Districts.....	92,410	217	79	...	...	...	3	...	1	9	...	...	...	...
VICTORIA.														
Melbourne	69,774	180	84	} 253	1	1	26	1	43	29	84	37	20	3
Suburbs	275,606	1,189	580											

METEOROLOGICAL OBSERVATIONS FOR APRIL, 1888.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.			Depth.	Days.		
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E.	94.2	66.2	45.4	30.110	...	Inches	...	...	...
*Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.	141.1	85.7	67.6	56.4	30.246	2.044	14	71	...	S.W.
*Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E.	82.4	56.6	33.3	30.091	.63	9	72	...	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E.	84.6	55.4	31.6	30.181	1.74	5	68	...	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E.	88.9	58.1	34.8	30.177	0.83	8	...	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E.	83.6	64.9	48.7	30.281	0.24	6	67	...	N.E.
*Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.

* The Statistics for New Zealand are those of the preceding month.

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

REMARKABLE CASE OF CIRRHOSIS OF THE LIVER.

READ AT THE THIRD ANNUAL MEETING OF THE NEW ZEALAND MEDICAL ASSOCIATION, HELD AT AUCKLAND IN MAY, 1888.

By J. CARNEGIE MACMULLEN, L.R.C.S.I., &c., HONORARY SURGEON AUCKLAND HOSPITAL, N.Z.

WILLIAM M'CORMICK, labourer, aged 46 years, native of Ireland, was admitted to the Auckland Hospital on August 3, 1887. He had a history of spirit-drinking, especially "nipping." Shortly before admission he noticed that his abdomen was swelling, but beyond slight occasional malaise had not felt ill.

On admission he was a fairly well-nourished, but spare man, of medium height, taking food with relish, and seemed cheerful. The abdomen contained a large quantity of fluid, the girth being 40½ inches, but there was no œdema of scrotum or legs. The tongue was clean, no jaundice, vomiting or diarrhoea, no marked tenderness on pressure, but suffered slightly from flatulence, the liver could not be felt. Heart and pulse normal, slight dyspnoea, no cough, and physical signs of lungs healthy. There had not been epistaxis, piles, hæmatemesis or melæna, nor were there venous stigmata or enlarged superficial veins. No delirium or convulsions.

He was treated with diuretics, diaphoretics, concentrated saline purges, &c., but without effecting any diminution in the size of the abdomen.

On August 20, I tapped him with a fine trochar, to the cannula of which was attached about 6 feet of india-rubber tubing. About 11 quarts of pale, clear fluid, containing much albumen, was drawn off, the hepatic area was then found to be much diminished. On August 27, he left the hospital for his home in the country, returning on September 2, when the abdomen was as large as before, he remained in the hospital until September 24 when he again went to his home at Pukekohe. From the date of his admission until he finally left, on September 24, a period of fifty-two days had elapsed, during which time the abdomen was emptied nine times, on each occasion as large a quantity of fluid being removed as at first. From this date I lost sight of him as he remained at home, where he was treated by Dr. Dalziel, of Pukekohe, to whom I am indebted for the further history of the case, which I give in his own words, he writes:—

"There was never any hæmatemesis, melæna, or other hæmorrhages, no enlargements of superficial abdominal veins; there was once a little jaundice, little more than perceptible for two or three days. There was frequent pain, which he referred sometimes to the liver and at others to the stomach. The abdominal wall gave way at the seat of the punctures four times, on the first occasion he sent for me and I used the trochar, the other three times he did not send, but allowed the fluid to drain away until it stopped, then re-applied the plaster. Including the tapplings at the hospital (I think nine), and the above-mentioned one, there were forty-seven operations, the three ruptures making up fifty. After the forty-sixth tapping he vomited almost incessantly for three days, the liquid vomited being similar to that drawn off by the trochar, and at the end of that time he was smaller than immediately after the operation. When the vomiting ceased the abdomen began to fill again. At the last tapping the fluid was green coloured, which it had never been before. I may state here, that after the vomiting ceased he was never free from pain in the abdomen.

"The average quantity of fluid drawn off equalled about twelve quarts, and there was about the same quantity at each of the three ruptures. Four days was the shortest, and eight days was the longest period between the operations.

"At the *post mortem* the fluid was of a dark straw colour, a small quantity being gelatinised, the stomach was adherent over nearly the whole extent of the posterior surface, it contained about two pints of dark green, thick fluid. On the posterior wall, about two inches from the pylorus (inner surface) there was an ulcer about the size of a sixpenny-piece, on the outer aspect opposite to this there was a small opening with raised edges, similar in appearance to the female urethra."

Dr. Dalziel does not describe the liver which he had already sent me. It was dense, contracted and markedly nodular, weighing only twenty-nine ounces, the average weight according to Murchison, and Hilton Fagge, quoting from *post mortem* records of Guy's Hospital, being about thirty-three ounces. The capsule was thickened and the gall-bladder so much so that it was of the consistence of wet leather. On section the characteristic appearances of cirrhosis were present, some portions being much more dense than others; the portal vein and vena cava were much dilated.

The principal points of interest in this case are the absence of almost all the symptoms usually

found accompanying portal obstruction, with the notable exception of the large and persistent ascites. The frequent necessity for paracentesis, and the failure to give relief no matter what means were adopted, the abdomen filling again within a few days of each operation, although it was only by the frequent removal of fluid that life was prolonged.

On the advantages of early tapping Murchison says (p. 288):—"The operation when delayed until the last is often followed by rapid sinking, with typhoid symptoms. On the other hand, the advantages of early tapping are, that by removal of pressure the establishment of a collateral circulation through the more healthy portions of the liver itself, as well as through the veins of the abdominal parietes, is promoted. Secondly, the functions of important parts, which had been impaired or arrested by the pressure, are restored. Not only are the lungs relieved, but by the removal of pressure from the portal and renal veins, assimilation and the secretion of urine are increased. I have known hæmorrhage from the bowels arrested by paracentesis in cirrhosis, and it is a common observation that patients with much ascites, who, notwithstanding the most powerful diuretics, have been passing only a small quantity of urine containing much albumen, will, after paracentesis and independently of drugs, void large quantities of urine free from albumen. And thirdly, diuretic and other remedies, which, when the abdomen is full of fluid have produced no effect, probably from not being absorbed, will often after paracentesis act powerfully, and thus retard or prevent the re-accumulation of fluid in the peritoneum. As soon, therefore, as the abdomen becomes moderately distended with fluid, and the remedies which I have mentioned to you fail to produce any effect, I would recommend you to lose no time in having recourse to paracentesis. Even should the fluid re-accumulate repeatedly, you need not despair.

"In case 115 the patient was tapped four times, and after the fourth there was no accumulation of fluid; while not long ago a case of cirrhosis was reported by Dr. Lyons, of Dublin, in which the patient was tapped 36 times at intervals of three weeks or a month, from 14 to 16 quarts of fluid being drawn off on each occasion, one year after the last tapping the ascites was stationary."

In a case which came into my hands about three years ago, there was a long history of spirit-drinking, the disease came on gradually, accompanied by jaundice and most of the usual symptoms. I tapped him four or five times, each time removing fluid deeply bile-stained—he was always more or less relieved. On the last occa-

sion on which I performed paracentesis, I was sent for hurriedly in the afternoon and saw him about four o'clock, he was then unconscious, could not be roused, and evidently at the point of death; having no instruments with me I had to return to town and reached him again about 8 p.m., he was then in the same condition, and so hopeless did the case appear that I did not expect any good result from tapping him; however, I did so, removing about six quarts of bile-stained fluid—he rallied a little almost immediately, and in forty-eight hours had so far recovered as to be able to walk to the wharf, a couple of hundred yards from his house at Devonport. From that time there was no further accumulation, he gradually recovered and went to America, and when I last heard of him he was still living. His illness, up to the time he left Auckland, had lasted fourteen months. Swelling of the legs was a marked feature in this case. He was allowed one pint of champagne daily.

NOTE ON THE IMMEDIATE TREATMENT OF RUPTURED PERINEUM.

READ BEFORE THE N.S.W. BRANCH OF THE B.M.A.

By RALPH WORRALL, M.D., M.Ch., Hon. Assist.
SURGEON TO THE DEPARTMENT FOR DISEASES
OF WOMEN AT THE SYDNEY HOSPITAL.

No one who has been in the habit of examining any number of gynecological cases can fail to have been struck by the large proportion in which the perineum has been more or less destroyed, and in which this accident is an important factor in the production of the symptoms for which the patient seeks relief. This fact, and the belief that there exists amongst some practitioners a tendency to ignore or imperfectly treat the lesion, has led me to bring the subject before you this evening. Before we can appreciate the full significance of the accident, and adopt efficient measures for its repair, we must have a clear idea of what the female perineum really is—we are apt to imagine that it is the skin between the post commissure and the anus, and unless our treatment be based upon a more correct notion, our patient will be little benefited. The latest writers on this subject describe the perineum as a pyramidal-shaped body of fibro-muscular tissue occupying the space between the lower portion of the rectum and vagina, and extending upwards for half the length of the latter. It owes its importance to its close connection with the muscular and tendinous structures of the pelvic floor, and has the following functions:—(1.) Deflects the anal canal

backwards, and prevents the anterior rectal wall pouching into the vagina. (2.) Gives a fixed point to the perineal muscles and fascia. (3.) Protects the inferior margin of the sacral segment of the pelvic floor, and thus, as Hart says, "is like the brass edge on a door-step." It is, therefore, clear that a ruptured perineum, which has been untreated, or merely hidden from view by uniting a curtain of skin in front of it, may give rise to symptoms of a serious kind. In my own practice I have noted the following direct and indirect results: Sub-involution and chronic congestion of the vaginal walls from the torn fascia no longer giving support to the venous plexuses; cicatrices on post wall, which are often very tender; a sagging down of the rectum and bladder, causing an alteration in the axes of these organs, and consequently a difficulty in the extrusion of their contents; to overcome this there is straining, and so a vicious circle becomes established, which, in some cases, leads finally to complete procidentia. The gaping vagina allows entrance to air, and dust, and cold winds, to the more or less permanent injury of the delicate uterus and its adnexa. Marital relations, too, are often painful to the woman and unsatisfactory to the man; I have several times been consulted in cases where this was the chief complaint. Finally, one can easily imagine how an unclosed wound of the perineum, over which decomposing lochia flows for some days, may easily be the channel by which septic germs enter the system.

Treatment.—It is impossible to satisfactorily repair this injury if the patient be in the usual obstetric position. She must be placed on her back across the bed, her hips brought to the edge, then, while an assistant supports the legs, the operator sits in front with a basin of hot carbolised water on his knees, into this he puts the needle threaded with a long piece of silver wire, needle-holder and two large pledgets of cotton wool; with these the wound is thoroughly douched; the first and second fingers of the left hand are then inserted into the rectum as a guide, and the needle mounted on the holder is entered less than a quarter of an inch from the right margin of the lowest end of the wound, and guided by the finger in the rectum, is made to sweep under the entire wound and to emerge at the corresponding point in the opposite side. As many sutures as may be necessary are passed in a similar way from below up, the highest bringing accurately together the upper margin of the rent. When all are passed they are twisted, beginning below; great care being taken to thoroughly cleanse the wound beforehand. Operating in this way I have generally had perfect union of all the torn tissues. I have had failures, for gentleness in passing the

catheter and keeping the parts clean is not always available, but even where no catheter has been passed, and but very imperfect cleansing, I have had complete success.

Quite recently, in the Nightingale Home, in Philip-street, I united, in this way, a complete rupture of the perineum, extending up the rectum for at least two inches, by four silk rectal sutures cut short, and four silver wire perineal sutures; the result (to which the nurse greatly contributed) was perfect union with complete control of the sphincter. Bringing the parts most accurately together, and making a large needle such as this, measuring two and a quarter inches from tip to tip, sweep right under the wound for its whole extent, are the principles which will most often lead to success.

The after treatment consists in passing the catheter every six hours, keeping the patient lying on her side with her knees tied together, and douching the parts frequently with carbolised hot water while the patient lies on the bed pan. Unless the nurse's skill be above suspicion, it is wiser to direct her not to insert the tube into the vagina for fear of disturbing the parts; this can be done by the surgeon himself if necessary.

The sutures are carefully removed on the seventh day (sooner if they are cutting), and the patient kept in bed for at least a fortnight.

In conclusion, I would urge that in every case of delivery the perineum be examined after the birth of the child, for it frequently happens that, while the head is passing through the ostium, no rupture is observed, yet subsequent inspection discloses a large rent.

CASE OF OVARIOTOMY.

BY ERNEST HUMPHREY, M.R.C.S. ENG., L.R.C.P.
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A.M., æt. 53. For eight months she had noticed her abdomen swelling, and had twice been tapped by Dr. Cutfield, who had at once recognised it as a case of ovarian dropsy; at the end of July I saw the case in consultation with Dr. Cutfield, and recommended her to have the cyst removed, but she refused. About a month after I saw her again, and called Dr. Clarkson in consultation; he also recommended its removal, and at this time she was suffering so much that she consented. On September 15 she had a black draught, and a soap and water enema on the morning of the 16th, the day of the operation.

Dr. McBurney placed her under chloroform, and, with the assistance of Dr. Clarkson, I proceeded to expose the cyst by an incision four inches long, and not having a large trocar I introduced two small ones, and allowed the fluid to run out; as soon as the tension of the cyst allowed it, I drew the cyst wall through the abdominal opening and opened it with scissors, I then introduced my hand and broke down several smaller cysts, and was soon able to get the whole cyst out through the wound. Three or four large adhesions had to be divided, having first put a catgut ligature round them. The pedicle, which was very broad and short, was ligatured with silk. I then carefully sponged out the peritoneum with a weak solution of carbolic acid till there was no trace of blood left behind and closed the wound with silk sutures, passing them through the whole thickness of the abdominal wall and including the peritoneum. The operation lasted fifty minutes, and patient remained in good condition. The wound was dressed with carbolic oil.

Nothing was allowed her by the mouth that day, but she was allowed to wash her mouth out every now and then with water. Her urine had to be drawn off once, but she passed it naturally in the evening; at 12 p.m.,—temp., 99; pulse, 84. An injection of morphia given her, gr. $\frac{1}{4}$.

Sept. 17. Passed a good night, some retching. Temp., 98; pulse, 76. Enemas ordered every four hours, beef-tea ziii , egg 1, brandy zss . 12 p.m., temp., 99; pulse, 92.

Sept. 18. Had a fair night, passed flatus freely for the first time. Temp., 98.2; pulse, 96. Her urine very offensive and running away. A catheter was passed to ascertain if there was any retention, but no urine drawn off. Bladder washed out with boracic acid, zi . to one pint.

12 p.m., Temp., 99.2; pulse, 88. Nutrient enemas to be discontinued.

19. Slept well, taking milk and beef-tea in small quantities. Urine not so offensive, and able to retain it.

20. Bowels well moved after a soap and water enema, had some fowl for dinner. Temp., 98; pulse, 84.

22. The wound dressed for the first time, all the sutures taken out, wound healing well.

October 5. Wound quite healed, a firm binder put round her, and allowed to get up.

REMARKS: At the present time, March 1888, she is quite well, and says she feels as well as ever she did in her life. There was nothing remarkable about the cyst, being an ordinary multilocular cyst of the left ovary.

Mackay, Queensland.

ON INTERNAL URETHROTOMY,
ACCORDING TO CORRADI'S METHOD.
READ BEFORE THE N. S. WALES BRANCH, B.M.A.
By THOMAS FIASCHI, M.D. ET CH.D.

IN the treatment of stricture of the urethra I divide my cases into three classes:—1st. Those presenting a narrowing of the urethral calibre, permeable to the smaller sized bougies, say, Nos. 2 or 3. These I always treat by progressive dilatation. 2nd. The old standing forms of stricture that have been previously treated by progressive dilatation, without any permanent improvement following, generally complicated with chronic urethritis, and sometimes also with chronic cystitis. The distinctive feature of this class is that they will allow a filiform bougie to pass through the stricture. These I treat by internal urethrotomy. 3rd. Those extremely rare and difficult cases of severe stricture altogether insurmountable even by the finest catgut or whalebone filiform bougies. In these the best mode of treatment left is external urethrotomy without a guide. A case of the kind I had the honour to present to you at the April meeting of the year 1888, and the notes of it are recorded in the 19th number of *The Australasian Medical Gazette*.

To-night I will draw your attention to a few cases of the 2nd class, presenting points of interest, but before doing so, I wish to remind you that there is hardly another branch of surgery in which the surgical mind is so divided in the matter of treatment as in stricture of the urethra; and even in the camp of the internal urethrotomists there are as many different methods of performing urethrotomy and as many urethrotomes, as there are surgeons.

You will then excuse me if I will first explain to you in what way I practice internal urethrotomy, and describe the instrument that I use. The urethrotome that I have selected is one of the many modifications of Maisonneuve's, but an extremely ingenious one, planned by Professor Corradi, of Florence.* It has the usual cannula guide capable of being screwed on to a filiform bougie. The blade, instead of being like Maisonneuve's, a triangular one cutting only on one side of the stricture, is in the shape of a nib, or better still, of a myrtle leaf, and cuts on both sides.

This blade runs with its middle line along the cannula and cuts the stricture by two bilateral incisions. Each of these is by one half less deep than the single one left by Maisonneuve's blade, thus diminishing the risk of hæmorrhage and of urinary infiltration. Also the centre of the two incisions

*Lo Sperimentale. Year xxxi, 1877.

corresponds more closely with the centre of the urethral perimeter, and enables us to restore the deformed urethra much more like its natural state. Corradi's blade has also the advantage on Maisonneuve's, that it has a shield enabling it to go through the healthy part of the urethra without injuring it.

The mode of using it is to pass the filiform bougie into the bladder, then to screw on it the cannula guide and to push this through the stricture into the bladder. You then fix on the cannula the blade portion, and protecting this well with its sheath, you slip it down the urethra until the stricture stops you. By means of a screw you then set free the blade and push it on. As soon as you receive the sensation that the stricture is divided, you draw the blade back, and fixing it under cover of the sheath you push it again through, and explore the remaining portion of the urethra. If another stricture is present, you divide it in the same way. This done, you can push your catheter into the bladder, but I prefer to pass first Corradi's three olive-shaped dilators, corresponding in gauge, the first to No. 10 of English scale, the second to No. 12, the third to No. 14. These, by their peculiar shape, open up the incision and prepare it for the reception of the catheter. An important point in the after-treatment, is to leave a full-sized catheter in the urethra for the four days following the operation. I said in the urethra, and not in the bladder, where irritation would certainly follow. The catheter is fixed by a lax tie to the penis, and every two hours or so the patient can push it gently into the bladder, draw the urine, and then stop hermetically the catheter with a plug and let it slip out of the bladder, so as to remain with its point in the prostatic portion of the urethra, just above the veru montanum. The retention of the catheter for four days through the divided stricture enables the work of cicatrization to take place in the right direction, and furthermore saves to a great extent, the patient from the danger of urine poisoning.

I have operated by this method of internal urethrotomy fourteen cases, and in all the result obtained has been good; no serious sequelæ, such as hæmorrhage, urinary infiltration, etc., following. In one case only had I urethral fever, and this, as you will hear, was due to my fault, not to the method. Of my fourteen cases, I will bring under your attention only those presenting some special point of interest.

1st case—P. McA., of Richmond, laborer, 70 years old, was admitted by me into the Windsor Hospital on the 3rd November, 1879, with the following history: For the last 30 years has suffered from stricture of the urethra, and has

repeatedly received advice and treatment for it, but never with any permanent good results following. Three years ago, in 1876, he was seized by an attack of complete retention of urine, followed by a perineal urinary abscess, for which he was treated in the Sydney Hospital. The surgeon there had considerable difficulty in overcoming the stricture, and passed a catheter into the bladder only after a fortnight's trial. This was followed by gradual dilatation with bougies, and, after a time he was discharged considerably better. He remained in a pretty good state for six months, when the difficulty in passing water returned, and for the last two years and a-half he has suffered greatly, passing his water with great straining and in dribbles. The water also has completely changed in appearance, becoming offensive, and leaving a ropy deposit in the chamber. On examination with a full-sized bougie, I found a contracted meatus and an insurmountable stricture at the union of the bulbous with the membranous portions.

The urine was ammoniacal, and contained large quantities of mucus and pus. I tried again to overcome the stricture with small instruments, but only succeeded in passing a filiform bougie. On this I screwed at once the cannula guide of the urethrotome, and tried to push it into the bladder, but the slight difference in size between the two instruments was sufficient to stop the guide from going through the stricture. Trusting then to the dilatation that always follows the presence of a bougie through a stricture, I left the filiform bougie in the urethra, and for fear of urethral fever setting in, I prescribed a solution of four grains of sulphate of quinine, to be taken every four hours. On the following day I found that the patient had passed a good night, only slightly feverish, and the urine had trickled alongside the bougie. This feeling much looser, I screwed on it the cannula guide, and passed it easily into the bladder. I then applied at once the urethrotome and cut the stricture, or rather the strictures, for there was a mass of thickened tissue extending fully one inch over one half of bulbous and membranous portions, evidently the remains of what pathologists call urethritis deformans. Immediately after, I passed easily along the guide an elastic catheter, No. 11, English scale, and this I left permanently for four days. During these the temperature did not rise above 100°. The after treatment consisted in the internal administration of quinine, and of copious potions of infusion of buchu, and of the daily washing out of the bladder with a weak solution of acetate of lead. On the 9th November I removed the catheter and continued for ten days to pass daily a No. 12 bougie, and to wash out the bladder. At the end of that time his water

had greatly improved, the stream of urine passed freely and without pain, and he was discharged with the direction, however, to pass a No. 12 catheter every week for the first two months, and after that every fortnight. I saw him again about a year after, and his aspect had greatly improved, and No. 12 could still pass easily. From the late Dr. Jockel I heard last year that he was still alive and doing well, having no more trouble from the stricture.

The chief point of interest in this case, independently of the long duration of the stricture, and of the old age of the patient, is the good result obtained, although the mass composing the stricture extended over one inch. This helps to restrict a statement made by an eminent authority on this matter—Mr. Harrison—“*that when internal urethrotomy is resorted to in a case where the mass composing the stricture was so extensive as to be amenable solely to perineal section, failure could alone be anticipated.*”*

My third case was that of a seaman who contracted his stricture in a somewhat unusual way. He had never suffered with his urinary organs till the year 1878, when he left England for Australia in a sailing vessel, bringing with him as a record of his last days on shore, a severe attack of gonorrhœa. Troubled by it, he consulted the skipper, who, for the nonce, left his nautical duties, and out of his medicine chest prepared for him an injection. This my patient immediately used, but the result was, according to his words, that he injected liquid fire into his inside, causing himself most terrible pain at the time and for many days after, which disabled him completely for the rest of the voyage. What this injection was he could not say, but he was never more able to pass his water freely, and on that account was not able to go back to sea. For two years he led a miserable life, until he entered as an inmate of the Windsor Hospital in the year 1881. Examination revealed stricture in the bulbous portion, of a very tight character, and surmountable only by a filiform. With him also, after screwing the guide on the filiform, I found that this was stopped by the stricture from penetrating any further, so that I had to leave the filiform in for 24 hours. On the following day I was able to pass the guide, and on this the urethrotome, operating upon him in the usual way. He made a good recovery and kept well ever since.

My fifth case was in the person of a strong, middle aged man, having a very sensitive urethra and an old standing stricture in the junction of the spongy with the membranous portions of the urethra. I generally perform internal urethro-

tomy without anæsthesia, for the pain is not very great, but with hyperæsthetic patients I make an exception, and in this case ether was administered by my friend, Dr. Faithfull. The operation was performed as usual, and the patient progressed very well. On the fourth day no rigors had taken place, the temperature had not risen above 100°, and he felt well and greatly relieved. I removed the catheter, and on the following day I passed Nos. 12 and 13. These went easily, and here I made a mistake by trying to improve on a good result. Thinking, perhaps, that the passage of larger instruments might further diminish the possibility of future return of the stricture, I passed No. 13 easily and No. 14 with some effort. He complained of the last instrument being too large, and hardly two hours had passed when I was called to see him. I found him suffering from very severe rigors, and in a state of extreme nervous depression. I administered at once large doses of quinine, but the temperature rose as high as 104°, and remained high for two days. Fortunately all passed off, but after that I took good care not to pass larger instruments than No. 12, and he made a good recovery and has kept well ever since. This case proved to me what I already believed, that the bruising or the laceration of the urethra by injudicious dilatation is really the cause of a great many cases of severe nervous disturbance and of urethral fever—perhaps more often than from poisoning from toxic urine.

My eighth case is a good illustration of the peculiar vagaries of stricture. My patient was a chemist, who had been for years poking instruments down his urethra, until the stricture refused admission to any of them. On my first visit on the 29th March, 1886, I was, after a few trials, able to pass a filiform, and, as the patient asked for anæsthesia, I removed it. On the following day Dr. Houston administered chloroform, and I then proceeded again to push the filiform, but could not; and after an hour of patient trials, using all the usual artifices and all sorts of bougies, I had to renounce for that day to penetrate this stricture. This taught me the error of giving an anæsthetic for internal urethrotomy, unless you have at the time a bougie through the stricture, for you cannot always pass one at command. For nearly a month I tried over and over again to get a bougie through without success, and as I had asked the patient to try himself, on the 26th April he sent me word that he accidentally had succeeded. I at once got Dr. Houston to give chloroform, and performed internal urethrotomy, followed as usual by good results.

My seventh and tenth cases I will record to you as a confutation to another rule laid down by

* Harrison's lectures on the "Surgical Disorders of the Urinary Organs." London, 1887, page 116.

Mr. Harrison, that no operation should be performed while there is any active suppuration going on in the urethra. If Mr. Harrison alludes to gonorrhœa he is right, but if he means by active suppuration, that purulent discharge so common in severe strictures, the result of chronic urethritis, especially if the patient has over-exerted himself or made too free in his cups, I think that his rule is open to criticism.

In my seventh case the stricture was a very tight one, complicated with considerable purulent discharge, increased when I saw it by a long railway journey; whilst in my tenth the discharge was always extremely copious and troublesome. In both these cases, that I operated in the presence of Dr. Faithfull, no bad result followed, but on the contrary, with the removal of the stricture the discharge diminished and gradually disappeared.

My eleventh case is interesting from its problematic etiology. The patient, a young man 19 years old, had never suffered from gonorrhœa, and still for years was suffering from great difficulty in micturition. On operating, I found a tight, hard stricture below the arch of the pubes. How did it originate? Mr. Distin Maddick, in his recent work on stricture, quoting the authority of Gross, mentions onanism as a remote cause of stricture.* My patient, however, stoutly denied having given way to such a practice, whilst he admitted that he had received a good many knocks and falls from carts in his life. He never remembered having hurt his seat nor having passed blood. I think, however, that the only manner to account for the origin of this stricture is that it was due to trauma, and that the pain in some other part of his body at the time drew his attention from his urinary organs.

My thirteenth case, operated by me on the 18th November, 1887, was in the person of a retired sea captain, aged 65 years, who for more than twenty years had suffered with stricture. When I first saw him he could only pass the smallest dribble of water, and this was greenish and putrid. I operated upon him under chloroform, administered by Dr. Houston, and, after dividing the stricture, the urethrotome, protected by its sheath, was in its further progress stopped by something gritty. I tried with a pair of forceps to extract the calculus, but, failing to do so, I cut from outside and removed a small spherical uric acid calculus. With this patient, as I always do when I suspect the urine, I washed daily the bladder with 1 in 10,000 solution of corrosive sublimate, and he did well, the external wound closing up completely.

My eleventh case was operated by me last month, assisted by Dr. Houston. The only

point of interest in it is that having undergone progressive dilatation years before, the stricture returned, and twelve months ago he was operated with Holt's dilator. After a fortnight he got bad again, and sank into the original bad state. After having performed internal urethrotomy, I got his opinion as to his personal experience of the two methods. This was that both as regards pain during the operation and constitutional disturbance after, dilatation is much the worse of the two, and that the relief and freedom in the stream of urine given by internal urethrotomy is infinitely greater. Although now a week and a-half have elapsed after operation he continues well, and yesterday morning I passed No. 12 with the greatest ease. I will watch the future progress of that case, being a good test as regards the value of the two operations.

I cannot conclude my notes on internal urethrotomy without referring to the new treatment of stricture of the urethra by electrolysis. The chief advocates of it, Dr. Robert Newman, of New York, and Dr. Steavenson, of London, extol its merits so highly, as to make me hope that it may substitute gradual dilatation in the first class of cases, and possibly reduce the number of those of the second requiring internal urethrotomy. That it will do away altogether with internal and external urethrotomy I hardly think, but only lengthened experience will decide this question. For my part, I intend giving the new method a fair trial, and hope at some future time to give you an account of my results with it.

Phillip-street, Sydney.

STRICTURE OF THE RECTUM.

READ BEFORE THE N.S.W. BRANCH B.M.A.

By T. F. MACDONALD, M.B., C.M., MEDICAL OFFICER PROSPECT RESERVOIR.

IN venturing to submit for your consideration to-night the record of a case of non-malignant stricture of the rectum, I do so not only as an argument in favor of its treatment by the operation of internal incision, but also in the hope that, by bringing the subject generally before you, some light may be thrown upon the obscure etiology of this disease.

I will therefore briefly run over the history of this particular case, and then in general terms touch upon the chief points which may arise for discussion, such as :—

- I.—Choice of operation,
- II.—Etiology,
- III.—Pathology,
- IV.—Prognosis.

*B. Distin Maddick, Stricture of the Urethra—1887. Page 23.

My observations will bear chiefly on that form of stenosis known as annular stricture, which is situated generally at from 1 to 2½ inches from the anus. Although in the case I am about to describe a second stricture was found higher up; but, as I look upon this second stricture as a result of the first, I will speak of it in that light.

History of the Case.—C. F. M., a clerk, aged 36, consulted me in regard to piles which were supposed to have existed many years, and for which he had undergone much medicinal treatment without effect. Twelve years or more ago, he remembered having difficulty at stool, attended with pain more or less; year by year the symptoms grew worse, till in late years his life had been rendered miserable with so much suffering; still growing worse the pains not only increased locally, but extended right down the legs and up the back as far as the neck, while after a more than usually severe struggle at stool, the voice would become quite husky, and cold sweats would not infrequently break out over the body; sometimes the stools were observed to be stringy in character, again in little lumps, while very often diarrhoea would obtain.

He now began to lose weight and strength, and to remedy this he took to athletic exercise, which I need scarcely say made matters worse; flannel rollers were worn to support the abdominal muscles, so great was the straining at stool. The intermittent attacks of diarrhoea would give relief from the more distressing symptoms for a time, only to be followed by constipation, which always brought with it an increase in pain and difficulty in defæcation.

There is an indefinite history of prolapse of the rectum in childhood, but none whatever of specific disease, nor are the glands in any way affected.

Such a history pointed to intestinal stenosis, and digital examination revealed a typical and well-marked annular stricture of the rectum, about 2 inches above the anus. The first impression to the touch was that which is experienced when the finger comes in contact with the os uteri when it is in a partial state of dilatation; this resemblance was very striking indeed. The orifice of the stricture was quite round and so small in size that it would admit no more than the tip of the forefinger, and any attempt at further exploration was rendered impossible, on account of the great pain which attended the least pressure on its circumference.

My diagnosis of non-malignant stricture was confirmed by Dr. Waugh, of Parramatta, who met me in consultation on the case. We thought

it advisable to try the effect of gentle dilatation by means of sponge tents, but this form of treatment had to be given up on account of the great pain which followed the swelling of the sponge; I may mention, however, that after the second tent had been removed it was followed by the discharge of a well-marked lymphatic cast of the intestine, formed by a mesh-work of lymph-tissue, with large, ganglionic-like formations here and there, from which the fibres of the meshes sprang. I looked upon this cast as the result of inflammatory processes beyond the stricture, but have, however, not been able to obtain any direct clue as to its origin. A similar cast was discharged some time afterwards.

The sponge treatment having failed to make any favorable impression upon the stricture, and more violent dilatation being obviously unwarrantable, I determined to operate.

Accordingly on the 6th of May, having administered chloroform, I was by this means enabled to examine more closely the relations of the affected part. The edges of the stricture at the orifice were about ¼ inch thick, and by forcing the finger partly through the aperture I could make out the base of stricture to be much thicker, probably about ½ of an inch. With a Cooper's hernia knife, I now nicked the edges, so as to allow of the introduction of a Weiss' dilator, and then gently but forcibly dilating, I carefully incised the stricture at three different points; the base of the formation was so hard that the sound of the knife could be distinctly heard in cutting. Withdrawing the dilator, I then found by further exploration with the fingers, a second stenosis about two inches beyond the first; this stricture would easily admit the passage of one finger, but not of two. It was formed in front by a hard mass of what appeared to be thickening of the mucous and sub-mucous tissues. This lump, which I took to be the result of old ulceration, was somewhat saddle-shaped, being about ½ an inch thick and an inch in length, the long diameter lying across the rectum; the constriction was brought about by two narrow bands of tissue, running round the mucous membrane, and attached at either end of the lump—one above, the other below. I cannot account for this strange formation in any other way than by the supposition that it was due either to ulceration with contraction, or to the infiltration of inflammatory products. I thought it advisable to divide this stricture, and accordingly introduced the dilator again, and after making a fair amount of pressure, I very slowly and carefully cut through the lump, after which I was able to dilate the instrument to its full extent without any resistance whatever. I now made a careful digital examination, and

assured myself that no perforation of the gut had taken place, and that the passage of the rectum was free, as far as I could reach with the fingers. I did not pass a bougie as there would have been great danger of perforating the wall of the gut should the instrument have chanced to enter one of the incisions. There was very little bleeding during the operation, although some clots of blood were passed about twelve hours afterwards.

The principal points in after treatment were, first, to prevent absorption of septic materials into the circulation, and second to sustain the patency of the rectum; which were successfully carried out, in the first place by the injection of dilute Condy's fluid, and a solution of iodoform, alternately twice a day; and by gentle dilatation every second day the wounds were made to heal in an open manner, so that now, three weeks after the operation, the patient has returned to his business, and he is able to pass normal sized stools naturally and without pain. Improvement in weight and general health is therefore to be expected.

I should have mentioned, that on the fourth day the temperature went suddenly up to 105°, but this alarming symptom was soon followed by a great discharge of fecal matter, which continuing at intervals for two days led me to believe there must have been a great accumulation somewhere in the intestine. Light diet, stimulants, tonics, &c., were given as required.

The strongest arguments in favor of internal incision as opposed to linean proctotomy seems to me to be—1. That in the former operation the sphincters are left intact and therefore there is no danger of incontinence.

2. The operation is in itself less severe, in so far as the destruction of tissue is not so great and consequently healing ought to be more rapid.

3. In the event of perforation of the bowel taking place, the wound can easily be united with sutures, failing this, the internal operation can easily be converted into the external by division of all tissues from the seat of perforation down through the sphincters, as would have to be done in the first instance if this form of operation were employed. At the same time I think the danger of perforation very remote if due care be exercised in the use of the knife.

Simple dilatation would be as useless in hard strictures of the rectum as it is in those of the urethra, while colotomy and excision should only be necessary in those strictures situated high up, and only then when met with in most severe form or where secondary complications require it.

Etiology.—As to the origin of stricture of this kind, I can find no satisfactory explanation in books, at least so far as I have been able to

read up; indeed, every theory but what seems to me to be the simplest of all has been put forward, and in hinting at an explanation of the matter I wish it to be understood that I do so more in the hope of courting criticism than in the desire to force your acceptance of my theory, which is:—

That strictures of this kind are formed by a method of natural evolution, the factors of which are, *atony of the rectum*, with consequent chronic constipation. In which condition very often there is known to be an accumulation of hard fecal matter at the lower part of the rectum; and that organ, not being stimulated to expulsion, the internal sphincter is called upon to support, for an unnatural length of time, a great increase in weight. The mucous membrane therefore, immediately above the sphincter, will thus be unduly squeezed between that tightly contracted muscle and the fecal matter above. In this way it is not unnatural to expect a ring of ulceration to be the result and thus the foundation of a stricture is laid. It is now only a matter of growth—by a process of constant irritation, granulation tissue will be continually thrown out all round the ulcerating ring. Increase in formation will react by increase in pressure, and thus the older a stricture is the more rapidly will it grow, until a climax is reached. An analogy might perhaps be made with valvular stenosis of the heart. There is one recorded case wherein complete occlusion of stricture of the rectum took place, producing rupture above, while a new passage was formed by the escaped material ulcerating its way into the rectum again below the stricture. Such is the case given by Quain, of Talma, the tragedian.

In further support of the above theory, I would point out that stricture occurs oftener in females than males,—the proportion being of three to one; and, although possibly the anatomical arrangement of parts in the female may have something to do with this predisposition of the sex, still I think the truer explanation lies in the fact, that by habit, &c., they are predisposed to constipation.

As far as the prognosis of my own case goes, I do not apprehend an unfavorable result, nor do I think the stricture can return so long as a careful lookout is kept on the state of the bowels, due attention being paid to the use of enemata, &c.

In conclusion, gentlemen, I have only to remark upon the imperative necessity there is for a thorough examination of the rectum whenever symptoms, in the slightest degree, point in that direction; indeed, be it only as a beacon of warning in the treatment of piles, I feel justified in having brought this case before your notice to-night.

CASE OF LITHOTOMY AND REMOVAL OF COIN FROM BLADDER OF SAME INDIVIDUAL AT DIFFERENT TIME.

By H. C. GARDE, F.R.C.S., SURGEON TO THE MARYBOROUGH HOSPITAL, QUEENSLAND.

On May 29, 1884, Charles J., aged 45 years, was admitted into the hospital, suffering from the usual symptoms of stone, which, on passing the sound, was readily detected, and a few days after I removed a uric acid calculus, weighing 246 grains, by the lateral operation. Nothing unusual occurred either at the operation or during convalescence, and he left the Hospital in good health on July 12, 1884.

On December 28, 1886, he was again admitted, suffering from symptoms of vesical irritation, and on making minute enquiries, the patient said that a three-penny piece was in his bladder. He was in a depressed state of mind, had tried to drown himself, and was brought in by the police. A couple of months previous he had some slight incontinence of urine, which he thought he could cure by passing a three-penny piece into his urethra; his idea was, that by placing the coin across the canal it would act as a valve, and prevent the urine from passing, and that when he wanted to micturate, by pressing it sideways, it would allow the urine to pass on either side, which it did in a forked stream. At first it answered his purpose fairly well, but soon began to get further into the urethra, until finally it slipped into the bladder, taking six weeks to perform the journey; so that, when he was readmitted, the coin was in the bladder fourteen days. On passing the sound, the foreign body was soon struck, giving a clear metallic ringing noise, and verifying the man's story, which at first, from his state of mind, I was rather dubious of. Owing to the rarity of the case, a consultation was called, and it was decided to try and remove it with the Lithotrite. On January 2, 1887, he was placed upon the table and chloroform having been administered, I passed the sound and made out the exact position of the coin, next passed the Lithotrite (Bigelow's) and at the second attempt caught it, the blades were screwed up and the instrument withdrawn; owing to the fact of the patient's urethra being of rather larger calibre than usual, little or no laceration occurred, although more than half of the coin projected from the side of the instrument; a thin film of phosphates covered it, giving it a slightly roughened appearance. No bad symptoms followed, and he left the hospital four days after the operation. Up to the present he has had no return of the

vesical troubles, neither has he tried any fresh experiments on his genito-urinary apparatus.

A formidable list of foreign bodies which have been discovered and removed from the bladder at various times, is to be met with in Heath's Dictionary of Practical Surgery, and as there is not a coin of the realm amongst the number, it possibly may be a unique specimen; at any rate, it is the first I have either heard of or come across personally.

NOTES OF A CASE OF OVARIOTOMY; DENSE FIBROUS ADHESIONS, COLLAPSE, RECOVERY.

READ BEFORE THE MEDICAL SOCIETY OF QUEENSLAND.

By WILLIAM S. BYRNE, A.B., M.B., HONORARY PHYSICIAN BRISBANE HOSPITAL.

MARY ANNA M., resident of Townsville, aged 43, married, six children, last one being now fifteen years old, consulted me in last April, stating that for the past six weeks she suffered from an abdominal swelling, and thought she was pregnant. On inspection she presented the appearance of being in the seventh month of gestation; on palpation there seemed to be two tumours, separated by an indistinct sulcus, and fluctuating all over. The Vagina was much elongated, the tip of the forefinger barely reaching the os uteri, and on passing the sound the length of the uterus was found to be four inches and a-half, the body being displaced to the left side, and the point of the sound felt through the abdominal wall. On the 12th May I operated, assisted by Drs. Hare and Little, Dr. Tilston administering chloroform. Shortly after commencing the anæsthetic the pulse became very weak and thready, and ether was substituted. The incision, which was two and a half inches long, was extended another inch, as, after tapping the cyst, extensive adhesions were discovered. There were three cysts, one large, one small, and one containing a great quantity of solid, brainy-looking stuff, which, having been removed in handfuls, the difficulty of freeing the cyst from the adhesions commenced. The cyst wall, beginning at the right corner of the uterus, was firmly bound down to the brim of the pelvis, from the pubes to the side of the sacrum. The original pedicle had evidently become attached, and where it ended and the cyst wall began, it was impossible to say. The portion of the cyst attached to the right horn of the uterus was transfixed and ligatured close to the body of the organ and divided, the remaining portion being treated in the same manner, till I had really made four or five pedicles. The

density of those adhesions it has never been my bad fortune to see before, I am sure I could have lifted the patient by them alone. There were several thick bands about the size of an ordinary slate pencil running from bowel to tumour, which were tied and divided; one however, during the manipulations, ruptured, and a quantity of blood was lost in a moment, though the vessel was picked up and tied at once. Towards the end of the operation, which lasted close on two hours, the patient became collapsed, the countenance livid and covered with a cold sweat, and we all feared, as no pulse was to be felt, that she was dying. Four subcutaneous injections of ether were given in about five minutes, the operation finished, the abdomen hurriedly sponged out, four deep sutures, and a drainage tube inserted, and the patient put to bed with hot-water bottles round her. In about two hours the temperature began to rise; there was a little vomiting, but she quickly rallied. During the first few days she was much troubled with flatulence, but the rectal tube gave her great relief. On the fourth day, soon after she micturated for the first time without the catheter, a rigor occurred, and the temperature went up to 104° , but next day it came down to 102° . She has for the past fortnight (it is now five weeks after the operation) been feeling well, eating well, and sleeping well; the temperature remains between 98° and 99° . She is getting up a little every day, so I may fairly presume she is convalescent. There are several points of interest in this case. Firstly, the woman's own statement that the tumour had been present but six weeks; with the amount of solid material and the density of the adhesions, I should measure its growth by years rather than months. Then, why should the uterus measure four and a-half inches; the elongation of the vagina is easily explained, but I have not yet come to a satisfactory reason for the great length of the womb. There were no abdominal symptoms whatever, the belly remained flaccid from first to last. After the third day I tried many purgatives, such as calomel, followed by Seidlitz powders and sulphate of magnesia, without any result; an enema of a pint and a-half of warm water also failed, but half an ounce of glycerine in a little hot water, injected into the bowel, acted at once. One lesson, and a valuable one, may be learned from this case, namely, to have the bowels freely opened by purgatives and enema every day for a week previous to operation; had this not been done here, the rectal tube would not have acted so well, as it was, the amount of flatus passed per anum was very large. I cannot close this paper without giving a word of praise to nurses Harley and Powys, for, I am sure, it is

owing in no small measure to their care and attention that I am able to record a successful issue to this severe case.

A CASE OF COCAINE POISONING.

By WILLIAM FINLAY, M.D.

ABOUT four o'clock in the afternoon of the 19th of March, 1887, I was summoned to see a young married lady who I was informed had been suddenly taken ill in a friend's house.

When I arrived, I found the patient lying on a bed, dressed; she was perfectly conscious, and could intelligently answer any question asked. She informed me that she had been to a dentist and had six teeth or stumps extracted, and for each tooth one grain of cocaine had been injected, by means of a hypodermic syringe, into the gum; in all, six grains of the hydrochlorate of cocaine. This information I afterwards learned from the dentist to be correct. On examination I found the skin dry, with extreme pallor and coldness over the entire surface of the body. Both eyes were widely dilated, and perfectly insensible to the brightest light. Pulse rate greatly lowered (38), very weak, and at times intermittent; the heart seeming almost exhausted. Breathing very slow (respirations per minute, five), shallow and irregular, with extreme dyspnoea. There were also well-marked spasmodic actions of both arms, during which she always clutched the attendant's hands or the bed clothes.

She complained of great pain in the back of the head, and also over the cardiac region, great difficulty in breathing and strong inclination to vomit.

Treatment.—The symptoms indicating that the immediate danger was from paralysis of the respiratory muscles and cardium, I at once thought of nitrite of amyl, but not being available at the moment, I administered a stimulant in the form of a tablespoonful of brandy in water, and followed this up by giving a large dose of tincture of digitalis (ʒ xxx) combined with aromatic spirit of ammonia. A sponge wrung out of hot water and put in a bowl was placed over the heart, and warm blankets wrapped round the legs and body. No improvement being apparent in half-an-hour, and respiration having almost failed, I then resorted to artificial respiration, and had the limbs well rubbed with brandy, this was continued for about three-quarters of an hour, when the cardiac action and respiration was greatly improved; the spasmodic action of the arms still continuing, but longer intervals intervening. After remaining with the patient for some time,

and no change for the worse being apparent, I retired to an adjoining room for a few minutes, when I was suddenly called for. On examining the patient I found her pulseless, and life apparently extinct. I again resorted to artificial respiration, and had the lips and gums well rubbed with brandy; this I continued for some little time with no apparent result, when I injected thirty minims of sulphuric ether into the flexor surface of the forearm, and as near as I could judge over the radial artery. Almost immediately afterwards I felt the radial pulse give a gentle fillip, when I again resorted to artificial respiration, hot sponge held over the heart, and rubbing the lower extremities with brandy. Very gradually the pulse and breathing was restored. This treatment was kept up at short intervals for about three hours, and I left the patient for the night about 10.30, to all appearances out of danger.

The following morning I found she had passed a good night. Eyes still widely dilated and insensible to light; complains of great languor and difficulty in walking; during the day was removed to her own home. I did not again see her till the third day (March 23), when I found her greatly improved and able to walk about the room, but still complaining of languor. Eyes still dilated, but re-acting to a bright light. Prescribed a tonic containing iron and strychnine.

The patient was five months pregnant, but the toxic action of the drug apparently had no disturbing effect on the uterine functions, as although she passed from under my observation, I afterwards learned that she was delivered of a healthy child at the normal period.

Bathurst, N.S.W., June 1888.

AN UNUSUAL CASE OF CHILD-BIRTH.

By C. H. SOUTER, M.B., C.M. ABERD.,
OF BINGERA, N. S. WALES.

THE following rather unusual case of child-birth I attended here may be of some interest to your readers.

A short time ago I was called, not having been previously engaged, to see Mrs. P.; I went without delay, and on enquiring I found that the patient, a healthy woman of 43, having borne six children without any serious complications, had been "in labour," as I was told, since the previous morning. A strong purgative had been given shortly before that, which had caused violent straining at stool. It was stated that the pains had stopped some hours since, and "the waters" had come away the night before. There was no history of hæmorrhage, delayed labour, or any

abnormality, and the full time of gestation had elapsed. The patient was sitting up in bed, and I could make out no untoward symptoms. Having satisfied myself that so far nothing unusual had occurred—admitting of diagnosis at the time—except the arrest of the pains, I made an examination, first having placed the patient in the usual obstetric position. The abdomen was very pendulous, and the patient complained of great discomfort when she assumed a supine position, or lay on the side, owing to some strain to the back received formerly.

I found the lower segment of the pelvis very roomy, and the soft parts dilatable; the os was fully obliterated; the head of the child presented in the second position. I could clearly make out the lambdoidal and sagittal sutures meeting in the posterior fontanelle, which was well down in the right anterior. I could not feel the anterior fontanelle. The head was not, however, in contact with the floor of the perinæum, which latter was not distended. No distinct caput succedaneum was palpable. A soft tumour was felt presenting between the right parietal bone, and the wall of the canal; this proved to be an accidental fold of the membranes retaining a portion of the liquor amnii.

A pain came on while I was examining the patient, and having given ext. liq. ergot 3i, in some cold water, and ruptured the secondary fold of the membranes, permitting some 3x of the liquor amnii to escape, I waited the natural progress of the case. The pains now increased in frequency, from every five to every two minutes, after a period of fifteen minutes quiet. Now and again I made examinations, and was surprised to see that no advance of the head took place. Thinking that the pendulous state of the abdomen might be the cause, I altered the position of the patient once or twice, but without result, though the pains were as strong and as frequent as ever. I now tried to free the occiput from a possible hitch on the anterior lip of the os, though I could make out no such condition. No result ensued, and seeing that the pains were as strong as before, and no exhaustion appeared, I waited for about half an hour.

The time that had elapsed since I witnessed the first pain was nearly two hours; the contractions became feeble and less frequent, and signs of some exhaustion showed themselves. I now thought it time to interfere, and I proposed the use of the forceps. To this the patient and her husband assented. I had brought a pair of Sir James Simpson's forceps in case of emergency, and proceeded to apply them at once, adopting all the necessary precautions and placing the lower blade over the child's left cheek, and the upper a

little behind the right ear. Having carefully adjusted them I waited for the onset of a pain, and pulling by the shoulders of the instruments, rotating very slightly in either direction. In three attempts of this kind I succeeded in bringing the head down to the vulva, and then reversing the hold and extending the head, delivered it. The rest of the child was delivered in the usual manner by the hands. The child was a healthy female. Having tied and cut the cord I gave *ergot. liq. m xxv.*, and waited for the expulsion of the placenta with my left hand on the fundus of the uterus. The pains soon reappeared, and there was a slight discharge of dark, loosely-clotted blood. No advance of the cord was seen, and in 15 minutes I examined again. I could trace the cord up a long way, but felt no sign of the placenta. Blood continued to be discharged, soon becoming of a brighter colour and fluid. Getting the nurse to continue pressing on the fundus, I passed my hand along the cord and presently came to the internal os, quite contracted and grasping the cord. I passed my finger through it, and this was also tightly grasped. On withdrawing it a fresh and copious flow of blood ensued. I now passed my hand up as a cone, and, with a great deal of difficulty, got first one, then two fingers, and finally my whole hand into the fundus. Much bright blood was discharged during this proceeding.

To do all this I had placed the patient on the back, still keeping up pressure on the fundus. I found the placenta completely detached inside the internal os, the fundus being moderately contracted, so that I had some difficulty in grasping the placenta.

With much trouble I succeeded in drawing it out, accompanied by the membranes and a quantity of blood clots. Having cleared out the uterus and delivered the placenta, I resumed the pressure on the fundus myself, and felt the uterus contract to the size of a closed fist, and thus I held it for 20 minutes.

Quite three pints of blood had been lost during all this, but, for obvious reasons, I could not make any accurate measurements. When the uterus contracted the hæmorrhage stopped suddenly.

The patient showed some signs of anæmia, exhaustion, and a tendency to syncope, which last symptom caused me to administer ʒii. of gin (the only available spirit), in warm water. However, the whole aspect was satisfactory and the pulse was fairly full and 90 per minute. I now applied a binder and a good-sized pad over the fundus, and, having personally superintended the arrangement of the patient in bed, I had the parts bathed with warm water and a warm linen cloth placed

between the thighs, as also a hot bottle to the feet. I ordered a nutritious but non-stimulating diet and the use of the bed-pan, besides which I prescribed a carbolic lotion, to be used externally twice a day, and a gr. i. opium pill, to be given in case of after-pains. The pulse being barely over normal, and the patient feeling comparatively well, I left within the hour.

The narrowed circumstances of the patient's husband led him to ask me if I could not dispense with any future visits, and, as I had not been engaged to attend the case, I agreed, under protest, to do so. At the same time I insisted that the fullest particulars should be sent to me daily for a few days, and that nothing should be given without my sanction. These conditions were fulfilled, and the patient now states that she is as well as she has been after any other confinements, and from what I have learned, I think it is fair to conclude that this is the case.

In conclusion, I look upon this case as one of so-called "hour-glass contraction" of the uterus, which condition was, I consider, the cause of the delay in the third stage, and along with, perhaps, the pendulous state of the abdomen, in the second stage.

The case was by no means unique, but may be of some interest when compared with others of a similar nature.

CASE OF RUPTURE OF THE STOMACH.

By LL. DAVENPORT PARRY, MEDICAL OFFICER
VEGETABLE CREEK HOSPITAL, ENNAVILLE,
N. S. W.

B, *ÆTAT* 60, was admitted to the Vegetable Creek District Hospital on June 18, at 12 noon, suffering from injuries received through the explosion of a charge of dynamite (which he was foolishly attempting to drill out) at the Little Plant Silver Mine.

Condition on Admission.—The left hand and wrist were completely shattered, and attached to the arm by a strip of skin on the ulnar side only. The patient complained of pain in the abdomen and great thirst, and on examination the epigastric region was found to be considerably reddened over a space of about six inches in diameter, and marked with about twenty small superficial wounds, such as might be caused by being forcibly struck by a quantity of fine gravel.

It was decided by Dr. Horton and myself, in consultation, to amputate the injured hand at once; and this was accordingly done at 2 p.m., the patient being anæsthetised by chloroform.

A few minutes after the completion of the

operation, and recovery of the patient from the influence of the anæsthetic, he sank into a state of collapse which, despite all efforts to rouse him, terminated fatally at 3.30 p.m.

Necropsy next morning.—On opening the abdomen the cavity was found partially filled with sour-smelling fluid and masses of partially digested food; the peritoneum was highly inflamed, and in the anterior wall of the stomach was an irregular rent $4\frac{1}{2}$ inches in length, through which its contents had evidently escaped.

Remarks.—I have ventured to send you these brief notes of the above case, partly on account of the comparative rarity of this accident from the shock of explosion, and partly to show the advantage of pressing for a *post mortem* examination in such cases, for there is little doubt but that the public would have been ready to blame the chloroform or its administrator in the above case, had not the necropsy revealed the serious nature of the internal injury.

PROCEEDINGS OF SOCIETIES.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE 71st meeting of the Branch was held in the Royal Society's Rooms, Sydney, on Friday, 1st June, 1888, at 8.15 p.m. Present:—Dr. O'Reilly (in the chair), Drs. Clay, Roth, Macdonald, M. J. Clune, Fisher, Marshall, A. Watson Munro, Martin, Bowker, Scot-Skirving, Crago, Hankins, Worrall, Clubbe, Wm. Chisholm, Pockley, Fiaschi, Megginson, Faithfull, and West.

Visitors:—Dr. Goode and Dr. A. T. O'Reilly.

The minutes of the previous meeting were read and confirmed.

A letter from Dr. Chambers, apologising for his absence, was read.

THE HON. SECRETARY (Dr. Scot-Skirving) announced that the result of the subscriptions collected for the widow of the late Dr. Leacock amounted to £112 17s, which had been forwarded to Mrs. Leacock.

DR. MACDONALD read a paper on "A Case of Stricture of the Rectum." (See page 245.)

THE CHAIRMAN (Dr. O'Reilly) said that the thanks of the members were due to Dr. Macdonald for his interesting paper. Perhaps at some future time Dr. Macdonald would report as to how the case was progressing.

DR. GOODE said he had listened to the paper with a great amount of interest, as he (Dr. Goode) had never met with such a stricture in a young man. He, however, remembered several cases of non-malignant stricture in young women. One in particular was that of a young woman of 21 years of age, upon whom he had operated with very satisfactory results. Another case was that of a young woman who had had stricture since she was fifteen years of age, but who positively refused to allow an operation to be performed. She was, however, relieved by dilatation. The case of Dr. Macdonald was interesting, as it was of such long standing, and the results of the operation had apparently been so good.

DR. WORRALL read some notes on "The Immediate Treatment of Ruptured Perineum." (See page 240.)

DR. CRAGO said that the matter mentioned in Dr. Worrall's paper was one worthy of consideration, as al-

though it might appear of small moment, still serious results might occur from neglect. The great difficulty he (Dr. Crago) had to contend with was getting the consent of the patient to having the sutures put in. He (Dr. Crago) remembered one case where he had put in two sutures and allowed them to remain in for a fortnight, but no union took place, whereupon he removed the sutures and the union took place almost immediately. He generally put in the sutures about half an inch from the edge of the split.

DR. FIASCHI said that Dr. Worrall deserved the thanks of the members for bringing forward this subject, as it was one point of preventive medicine which if attended to at once saved a good deal of after trouble. The operator who deals successfully with a ruptured perineum at the time and thus does not neglect his duty, is more worthy of praise than the expert surgeon who performs major operations.

MR. G. T. HANKINS said that the opinion as to the immediate treatment of ruptured perineum was very much divided, many recommending that it was better to let the rupture remain untouched for 24 hours, when the swelling of the parts had been reduced and the stitches had a better chance of remaining intact. This opinion was shared by Dr. Worrall's colleague, Dr. Chambers. As to obtaining the patient's consent to the operation he (Mr. Hankins) had no difficulty, as in almost all these cases he used a little chloroform, and as the patient was generally more or less under its influence there was no difficulty in putting in the stitches. He (Mr. Hankins) remembered one case in which he delayed putting in the sutures, and the results were not altogether satisfactory.

DR. POCKLEY said he was led by a remark he heard fall from Dr. Chambers to delay operating, but not for so long a time as mentioned by Mr. Hankins, only for about 8 or 10 hours, and had always had good results. He refrained from ordering douches except when he could either carry them out himself or see that they were properly carried out.

DR. WORRALL, in reply, said that he never experienced the difficulty mentioned by Dr. Crago as to getting the consent of the patient, as he never asked for it but insisted upon operating if it were necessary. He (Dr. Worrall) thought it was a bad thing to take in too much of the skin. He thought that the sutures should not be put in more than a quarter of an inch, and you might then reckon on getting perfect union. With regard to doing the operation immediately, there were many points in its favor. He (Dr. Worrall) always made a practice of doing the syringing himself.

DR. FIASCHI read a paper on a case of "Internal Urethrotomy." (See page 242.)

DR. GOODE was very pleased with the paper read by Dr. Fiaschi. There was one point about the urethrotome exhibited by Dr. Fiaschi, and that was, that it made two small nicks instead of severing the stricture by one cut as in the case of Thompson's or Berkeley Hill's urethrotomes.

DR. WORRALL said he thought that the knife that made one deep incision was better than one which made two smaller cuts, as you could feel the dense side of the stricture and direct the knife to that side, and so sever the stricture at one cut.

DR. SCOT-SKIRVING said he had not had as much experience in this operation as Dr. Fiaschi, but in what cases he had operated upon he had always used Thompson's or Otis' urethrotome. He (Dr. Skirving) thought that there was an advantage in using an instrument which made one deep incision, rather than one which only made two smaller ones, as it appeared to him that to make two small cuts might only tease the stricture

instead of severing it properly. He preferred an incision in the floor of the urethra to lateral cuts. What Dr. Fiaschi mentioned as regards hyper-dilatation he (Dr. Skirving) could fully bear out, as in one case where he had been using a No. 15 bougie, alarming symptoms occurred similar to those described in the paper just read. As regards tying in the catheter, it should always, he thought, be tied so that the point does not remain in the bladder. Fever in these cases is very often due to irritation of the neck of the bladder.

MR. G. T. HANKINS said he had assisted Dr. Fiaschi in one of his later cases of stricture, and was very pleased with the urethrotome used by him. In such cases as the one brought forward by Dr. Fiaschi, it was very important that the stricture should be properly divided. The instrument he (Mr. Hankins) liked most was Otis, he having only used Berkeley Hill's and Thompson's instruments once. As to whether the catheter should be allowed to remain in the urethra after the operation, the arguments most used against the practice being that it induced fever, he (Mr. Hankins) thought that the better plan was to tie the catheter so that the patient could push it into the bladder whenever the bladder was to be emptied. Another point in Dr. Fiaschi's paper was that of passing a series of different sized bougies. He (Mr. Hankins) always passed immediately after the operation the largest sized bougie the incision would take, so as not to dilate after the operation, and if the bougie will not pass freely withdraw it and cut again.

DR. FAITHFULL said he had assisted Dr. Fiaschi in several of the operations mentioned in his paper. He (Dr. Faithfull) did not believe in hyper-dilatation. Fever was very often brought on by the irritation of the external orifice.

DR. FIASCHI, in reply to Dr. Hankins, said he did not pass the bougies after the operation for the purpose of dilating, but merely to clear the way for the catheter. In the case of making a single deep incision there was sure to be more hæmorrhage than when two smaller incisions were made. Fever in these cases was very often brought about by the nervous influences and not by the urine at all, for it was not all urines that would produce fever in these cases. As regards Dr. Worrall's question as to what were considered good results, he (Dr. Fiaschi) said that if at the end of the operation you pass say a No. 12 catheter, and at the end of twelve months you can pass the same number, surely that can be called good results.

SANITARY SECTION OF THE ROYAL SOCIETY OF NEW SOUTH WALES.

THE tenth monthly meeting of the Sanitary Section of the Royal Society was held in the Society's rooms, Elizabeth-street, Sydney, on June 12. Present:—Messrs. J. Trevor Jones (in the chair), R. Hunt, J. Willshire, W. Redfearn, J. B. Henson, Drs. Goode, Ashburton Thompson, Lyden, Bancroft (Brisbane), and R. E. Roth (Hon. Sec.) Dr. Carruthers read an interesting paper on "The Disposal of Sewage." Amongst other matters he alluded to the quantity and money value of human excreta, the excreta of one adult being variously estimated at from 8s to 18s per annum. Attention was also drawn to the advantages and disadvantages of the various forms of sewage disposal, such as water carriage and run into the sea or on to tracts of land for agricultural purposes. An interesting discussion on the paper followed.

SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

ANNUAL MEETING held at the Adelaide Hospital on June 28, 1888. Present: Dr. Davies Thomas (in the chair), Drs. Lendon, Laurence, Mackintosh, Poulton, Stewart, Stirling, Todd, H. H. Wigg, Messrs. Aitken, Clindening, Cookson, Corbin, Giles, A. A. Hamilton, Hayward, Martin, Moore and Cleland.

The minutes of the meeting held May 31, 1888, were read and confirmed.

ANNUAL REPORT.

The Council has to report that during the past year no questions specially affecting the medical profession generally have been brought under its notice. At the May General Meeting the recent action of the Medical Board in remonstrating at the pressure brought to bear to cause it to register qualifications deemed by it to be worthless, was thoroughly endorsed and a motion was carried to the effect "that this meeting desires to express its confidence in the Medical Board."

Now that the first Intercolonial Medical Congress has become a matter of history, the Council, on behalf of the Society, cannot refrain from congratulating the members on the eminent success of the undertaking. Your Council feels sure that had it not been for the existence of such a Medical Society as that of which you are members, the holding such a Congress would have been rendered much more difficult, if not altogether impracticable. Your Council would draw special attention to this point for the encouragement of those members who unfortunately are, owing to circumstances, but seldom able to attend the meetings; as showing that by their subscribing to a joint fund for a common end, concerted efforts are able to achieve brilliant results.

In consequence of a motion carried at the last Annual Meeting, your Council has ceased to have the proceedings of the meetings printed in a separate form for distribution to the members. In lieu of this the members now receive copies of the *Australasian Medical Gazette*, the Editor of which has kindly agreed to print reports of the meetings and the papers read, for about the same expense as that formerly incurred by the separate publication of the proceedings. There is a manifest advantage in this, as members are enabled to see reports of other Australasian Medical Societies, and the doings and opinions of the medical profession generally in the Colonies. To render the reports as complete as possible, the assistance of Dr. Poulton, as co-editor with the Hon Secretary, was secured, and the results have been such as to cause every satisfaction.

Respecting Public Health, a deputation was formed to interview the Commissioner of Public Works, to ask what arrangements the Government intended making to ensure the effectual carrying out of the deep drainage of the city, and water conservation generally, on the dispensing with the services of the Hydraulic Engineer. The deputation was dismissed with the usual official reply, and failed to elicit any information on the subject of a satisfactory nature. The action of the Society last year with respect to the pollution of the water-shed of the Hope Valley Reservoir has also failed to move the authorities to take any steps towards rectifying such a highly dangerous and possible source of water contamination.

Since the last Annual Meeting eleven new members have been elected, and seven members have resigned on account of leaving the colony or of ill-health. This makes the total number of members 76, or an increase of four.

The receipts for the year amount to £163 0s. 6d. The expenditure to £129 12s. 9d., and there is the sum of £115 11s. 10d. to the credit of the Branch in the Savings Bank.

The Annual Report and the statement of Receipts and Expenditure were adopted unanimously. The balance-sheet and vouchers were laid before the members.

The retiring President (Dr. DAVIES THOMAS), then read the following

PRESIDENTIAL ADDRESS.

GENTLEMEN,—Twelve months have rolled by since I had the honor of first occupying the Presidential chair of this Branch of the British Medical Association. During this period, much has taken place that is of interest to the members of our profession all the world over, and not a little that possesses a special and local interest to ourselves.

To take the affairs of our microcosm first :—

I have the pleasure of congratulating the members of the South Australian Branch upon the continued prosperity of their Society : This is marked not only by an increased numerical strength, but to a higher and better degree by the excellence of much of the work done by its members ; where so much that is good has been accomplished, it would be presumptuous in me to single out particular contributions for special comment.

I also congratulate my fellow members of the Branch that we have not been visited, during the past year, by the hand of death ; the present number of members is 76 ; during the past year seven members have, from various causes, left the Society, but on the other hand, eleven new members have joined it.

The financial condition is also highly satisfactory. One event of particular local and of general Australian interest has been the occurrence of the First Meeting of the Australasian Intercolonial Medical Congress. This, as you all know, was held under the Presidency of our last President, Dr. Verco ; need I remark upon the pardonable pride we feel at the admirable manner in which that gentleman sustained the honorable office which was so judiciously bestowed upon him.

We acknowledge with satisfaction, that our brethren from the sister colonies have been generous enough to express their approval of the efforts made in South Australia, both for their entertainment and for the discussion of questions of interest and importance, alike to the public and to the members of our profession.

It appeared, during the Meeting in question, to be the general opinion of the members present, that the next meeting of Congress should not take place for three years, and that it should be held at Melbourne ; but it was decided that the question of the selection of the time of meeting should be entrusted to the members of Congress resident in Victoria.

Our Victorian *confrères* have, no doubt after mature deliberation, decided that the next sitting of Congress shall take place in January of next year, it only remains for us not only to wish them success, but also to do what lies in our power to assist them to achieve it ; I venture to express the hope that the members of this Branch will endeavour to contribute papers to be read and discussed at the coming meeting.

A subject of national importance and presenting features of special interest to us as medical practitioners in Australia, is the enquiry now being prosecuted into what is fitly designated the Rabbit Plague ; it is unnecessary for me to dwell upon the disastrous proportions to which this nuisance has attained ; for it is known to all of us ; but the aspect of the question that more particularly interests us is how far it will be found

possible to introduce among these animals a disease which, whilst proving mortal to them, shall not be injurious to other animals. This bids fair to become one of the most important enquiries yet entered into in the comparatively new domain of Comparative Pathology.

Having thus briefly adverted to matters of merely local interest, let us cast our eyes over the greater outside medical world.

It has often been urged as a reproach against the professors of the Art of Healing, that its progress has lagged greatly behind that of the other natural sciences, and that, in fact, medicine and the allied branches of curative art are not sciences, but rather mere empirical arts. It must be confessed that this is, in a certain sense, true, for at the present we can, but to a limited extent, reduce its data to the decisive arbitration of figures, whether dealing with time or space.

The physician is now able to express with mathematical exactitude the variations of caloric and of electro-motive force ; he can span the sunbeam and measure the sound-wave ; but alas ! the great problem of vital force with its momentous issues of Life and Death, is yet unsolved by the physiologist and the physician. By what measure can we gauge the mysterious forces latent in the nerve-cell or in the germinal vesicle, and what is the subtle essence that we call Life ?

But when we reflect that experimental enquiry upon man himself is, from the nature of the case, almost entirely precluded, and that such observations when made even upon the higher mammalia must be applied with great caution to the case of man, and that in fact, most of our inductions with regard to the diseases of man are based upon the method of Agreement and are amenable to its numerous fallacies, then we may indeed with justice congratulate ourselves that so much has already been achieved. But there yet remains a wide field and an abundant harvest to invite the labors and reward the toil of the earnest and humble worker.

It is evident that the progress of medicine in the future must largely depend upon advances in the other natural sciences, for in truth these sciences constitute a brotherhood or partnership whereby each profits by the advances made by the others.

Let us for a moment take the case of Chemistry in its relation to Physiology and Pathology.

The early career of Chemistry was essentially analytic or destructive ; its later developments are synthetic or constructive. It is a strong human instinct that inspires man not only to desire to learn what things are made of, but also to constitute himself a builder ; the unwearied yet ever-tantalising search for the Philosopher's Stone illustrates this yearning to construct.

Analysis has especially characterised Chemistry in its relation to Physiology and Pathology ; it has determined for us the atomic construction of the excretory products, urea kreatin, uric acid, &c., probably not only as regards their ultimate analysis, but even as concerns the atomic architecture of their molecules ; and it is true that we are instructed as to the ultimate constitution of albuminoids, peptones, ptyalin, &c., but what know we of the relations of their component atoms and of the subtle changes whereby a beef-steak gives birth to a thought ?

That respiration consists essentially of oxidation, and that our expired air contains carbonic acid and watery vapour is doubtless true, but has Chemistry yet explained to us why urinary and renal calculi form or in obedience to what chemical laws calcification of the arteries results.

But in chemical science we have entered upon a new

epoch, a constructive one; when, in 1828, Wohler made his memorable discovery of the synthesis of urea, in doing so he broke down for ever the chemical barrier that had hitherto separated the products of the animate and inanimate worlds. By slow but accelerating strides has synthetic organic Chemistry advanced during the past half-century, and to-day a vast number of so-called organic bodies can be prepared in the laboratory of the chemist. Of special interest to us, as practical physicians, is the synthesis of a number of valuable therapeutic agents, *e.g.*, anti-pyrim, &c.

The discovery that by the artificial substitution of certain organic radicals in some complex bodies, correlative pharmacological differences result, is one, the significance of which it is difficult to over-estimate in its bearing upon practical therapeutics.

In the domain of Optics we may congratulate ourselves upon the wonderful excellence of the new Apochromatic lenses elaborated with such toil by Zeiss, of Jena, whereby it is claimed that a much more perfect concentration of the rays is attained than with the best objectives hitherto made, and that there is neither focal difference nor spherical aberration even in the case of the chemically effective rays.

When we consider the great service that microscopical science has rendered to Medicine, we cannot but hail with gratification any improvement in its principal appliance.

With regard to Acoustics in their relation to Medicine; there seems to be but little to comment upon, in the way of advance; this is to be regretted, for useful as are our present stethoscopes, we cannot but think they might be improved upon. It would appear that some modification of the microphone might be devised which would extend our powers of auscultation. It is needless to insist upon the value of any practicable instrument of this character, for example:—It is known to all of us that considerable difference of opinion has existed, and indeed still exists, as to the time-relations of the so-called pre-systolic murmur of the heart. It is generally believed to be due to the blood-current flowing from the auricle to the ventricle through a contracted mitral orifice, and that it precedes in time the pulse in the great vessels as felt at the root of the neck; it therefore precedes also the first sound of the heart and the moment of maximum apex-beat.

On the other hand, many physicians, *e.g.*, Dr. Dickinson, regard it as ventricular-systolic in time.

It seems to be almost hopeless to decide this and similar questions by appeal to the ordinary methods of auscultation.

It therefore occurred to Dr. Byrom Bramwell, that by some modification of the phonograph or of the microphone, it might be possible to record upon a revolving drum, the time of such a doubtful murmur. Simultaneously, the movements of the apex-beat could be registered on the same drum, and thus the mutual time relations of murmur and apex-beat would be automatically written without the possibility of error.

Impressed with the desirability of this, Dr. Bramwell has pointed out to Mr. Edison, to whose inventive genius the world owes so much, how valuable would be an instrument which could record automatically and if necessary reproduce, the sounds of the heart and lungs.

It is satisfactory to learn that Mr. Edison has promised to consider the question.

Meanwhile, Dr. Bramwell, in conjunction with Dr. Milne Murray, has advanced a step in this direction, by the use of an apparatus by means of which are registered on a revolving drum, simultaneously, a cardiographic tracing of the apex-beat, and a tracing which represents the exact moment at which the auscultator (Dr.

Bramwell) heard and signalled a cardiac murmur. The signal was instantaneously conveyed by an electric which was "made" by the closure of a Morse's key, at the instant when the auscultator heard the murmur.

In this case, however, the possibility of an error of observation is not eliminated.

Since the time of Duchenne, of Boulogne, electricity has been a useful hand-maiden to medicine, but it has been a somewhat erratic one, principally in consequence of the want of a convenient measure of the dose of this agent; it is needless to remark that to speak of the employment of so many cells meant nothing definite, for the electro-motive force of a cell varies according to the amount of work it has done, &c.

To-day, however, we have at our disposal "ammeters," by which the actual dose of electricity can be measured, that made by Gaiffe, and exhibited to you now, measures up to 50 milliamperes and answers for the ordinary uses of the continuous current, but for the powerful currents employed by Apostoli for intra-uterine treatment, it is requisite to act with currents up to 240 or even 300 milliamperes.

And this leads me up to an allusion to what promises to be one of the most striking advances in gynæcology; I refer to what is called Apostoli's treatment.

UTERINE ELECTRO-THERAPEUTICS.

Various attempts have been made by different physicians to act therapeutically upon the diseased uterus by means of electricity; one of the most considerable of these was the employment by M. Tripier, of Paris, of Faradisation for hypertrophy of this organ.

Apostoli, a pupil of Tripier, began in 1882, a new course of procedure with results so satisfactory to himself, that in 1884 he submitted a memoir on the Electrical treatment of Fibrous Tumours of the Uterus to the Academy of Medicine in Paris.

Apostoli's work seems to have received but scant notice in Great Britain, until recently, when the communications of Drs. Elder, Webb, Thomas Keith, Sir Spencer Wells, and others, have at last drawn attention to its unquestionable value.

Thomas Keith, in December, 1887 (*Brit. Med. Journ.*, Dec. 10), declared that "Fortunately for those afflicted with uterine tumours, it now matters little which of the old ways of operation is best; whether the ovaries can be removed or not; whether the extra or the intra-peritoneal method be the better way of performing hysterectomy, or whether the convalescence lasts in the one case six weeks, or in the other twenty days; the treatment introduced by Dr. Apostoli must take precedence of all others. The success of this treatment is a great fact, and in saying that I accept 'toto animo' his teachings, I do not speak without some experience of his practice."

Almost equally strong testimony has quite lately (*Brit. Med. Journ.*, May 12, 1888) been borne by Sir Spencer Wells to the brilliant promise of this plan of treatment.

Surely, Gentlemen, when we recognise that, according to tables compiled at Paris in 1886, the chances of a woman who undergoes myotomy are two to one against recovery, we must joyfully welcome any plan of treatment that promises to rob death of some of its victims.

DR. APOSTOLI'S TREATMENT.

1. The method consists essentially in the application of a continuous current of electricity, à l'état constant, to the uterus, without any interruption during the operation.

2. The seat of the application, by means of a sound of platinum, is always intra-uterine, and the whole extent of the mucous surface should be acted on.

3. In the case of the cavity of the uterus being unattainable, a preliminary puncture must be made in the hypertrophied body, followed by negative galvano-caustic action, so as to set up an artificial channel.

4. The active intra-uterine pole must be positive in all cases of hæmorrhagic fibromas, or when there is the accompaniment of obstinate leucorrhœa; negative in the opposite cases in which the great trouble is dysmenorrhœa. The local effect of the two poles is very different. The positive pole is coagulating and hardening; the negative pole causes liquefaction of the tissues with which it comes in contact, and often causes some hæmorrhage. This may always be controlled by the positive pole.

5. The greatest possible strength of current compatible with the toleration of the patient, and the effect desired must be employed.

6. The application of the current on an average of from five to eight minutes is necessary to produce effective cauterisation.

7. The number of applications required to ensure a reduction of the size of the tumour will vary according to the nature of the disease and the object sought for.

8. Generally speaking, the treatment will require an operation twice a week, and if necessary, even during the presence of active hæmorrhage.

9. To overcome the pain and prevent the eschar caused by high-tension currents (from 50 to 300 milliamperes) on the skin of the abdomen, an electrode of wet potter's clay was first proposed by Dr. Apostoli, and is used. This increases its surface, and diminishes the resistance of the skin.

10. The operation is virtually a uterine cauterisation, in which the highest possible degree of electro-chemical action is used.

11. This intra-uterine galvanic action brings about a rapid elimination of fibroid tumours, but not their total destruction. Hæmorrhages are arrested, the woman's powers are often restored, and health is assured.—*Brit. Med. Jour.*, May 7, 1887.

Dr. Apostoli claims that his electrical treatment is efficient not only in the case of uterine fibromata, but also for various inflammatory conditions connected with the uterus and its appendages; for example, in a recent number of the *Brit. Med. Jour.* (May 12, 1888), he records a case of hydro-salpinx cured by his method, and he draws the following conclusions, viz. :—

1. In gynecology fever and inflammation are not to be regarded as absolutely contra-indicating the methodical and proper application of the galvanic current.

2. Inflammation of the uterus and its appendages, when not in the stage of suppuration, may be advantageously treated by the galvanic current. This current, though admissible in the first stages of congestion and inflammation, I consider ought not to be used when suppuration exists, unless it be brought into action in the form of an electrical cauterisation, for the purpose of making a safe and certain outlet for the matter through the vaginal wall.

3. A galvano-caustic puncture is a valuable means by which we may gain two ends; first, to check the outbreak of inflammatory action, or to stop its progress; secondly, to give an easy exit to a collection of fluid, by the falling of an eschar, in any case, where the cavity containing such fluid is accessible through the upper part of the vaginal wall.

4. Every inflammatory exudation presenting itself in the vaginal cul-de-sac may be treated by means of the galvano-puncture, except under the condition I shall hereafter mention.

5. This method may be easily and harmlessly employed for the treatment of certain cases of salpingitis

and hydro-salpinx, on account of the close relation between the tumours and the vaginal wall.

6. In making every galvano-puncture, all the rules which I have hitherto laid down concerning the seat of the puncture, its depth, the size of the trochar, the antiseptic precautions, the repose of the patient, &c., must be scrupulously observed.

7. Two negative galvano-punctures, vaginal only, were sufficient in one case of hydro-salpinx to bring about very quickly an important anatomical change, and complete symptomatic cure.

And now, in conclusion, gentlemen, permit me to thank you for having elected me your President for the past year, and to make way for my successor, Dr. Stirling.

DR. STIRLING (the President Elect), then took the chair. Having expressed the pleasure he had felt at having listened to Dr. Thomas' address, he asked that a vote of thanks be accorded to the retiring President.

Mr. HATWARD rose to move a vote of thanks to Dr. Davies Thomas for his very excellent and interesting address. He referred to the fact that Dr. Charles Gosse, a former President, had been the first to initiate such an excellent precedent, which, he hoped, all succeeding Presidents would follow.

MR. CLINDENING warmly seconded the motion, and spoke in flattering terms of the retiring President.

DR. MACKINTOSH also supported the motion, which was carried with acclamation.

DR. DAVIES THOMAS returned thanks for the kind manner in which his remarks had been received.

ELECTION OF COUNCIL FOR 1888-89.

President Elect, E. C. Stirling, M.D.; Vice-president, W. L. Cleland, M.B.; Hon. Treasurer, T. W. Corbin, M.R.C.S., Eng.; Hon. Secretary, B. Poulton, M.D.; Members of Council, A. A. Hamilton, M.B., T. W. Hayward, M.R.C.S., Eng., J. Davies Thomas, M.D.

MEDICAL SOCIETY OF QUEENSLAND.

MONTHLY meeting held on April 10th, in the School of Arts, Brisbane. Members present—Drs. Little, Tilton, Hardie, Gibson, Jackson, Shout, Hare, W. S. Byrne, E. H. Byrne, Clowes, Owens, Hill, and Chas. Keibell. Visitors—Dr. Thorpe, R.N., and Dr. Edgewell, of South Brisbane. Dr. Hill conveyed the apologies of the Secretary to the meeting for his absence.

Dr. Jackson showed a boy, in whom a piece of bone had been removed by trephining for a depressed fracture of the left temple—the bone removed, being larger than a crown piece.

Dr. Jackson also showed a boy, who had received a gun-shot wound, four years ago, below and slightly to the left of the left orbit. A probe could be passed to the opposite parietal eminence. The bullet, as far as is known, is still in the head. Since the accident the boy had enjoyed excellent health with the exception of an epileptic fit some days ago.

Dr. Hill showed, for Dr. Love, an infant four weeks old, the subject of congenital rickets and exhibiting the condition known as cranio-tabes in a marked degree. The bones of the cranium were merely represented by a few floating islets of bone in the right frontal and left parietal regions. The long bones were much curved and there was a double inguinal hernia. The mother was only 4ft. 3in. high and looked decidedly rickety.

The minutes of last meeting were read and confirmed.

DR. JACKSON then read the notes of the case of trephining (patient exhibited).

DR. SHOUT then took the chair, while DR. LITTLE proposed the motion standing in his name, "That the Medical Society of Queensland considers it necessary that the State should provide control of chronic inebriates other than sending them to gaol or waiting till they have qualified themselves for admission to a lunatic asylum."

[Dr. Little's remarks were practically the same as he published in the September number of the *Gazette* for 1887, p. 299-300.]

DR. GIBSON concluded that dipsomaniacs were monomaniacs and on that could be certified insane. However, he considered the law in Victoria and at home as of some use, as many voluntarily placed themselves under control. However, he considered it desirable that the nearest friend should be given power to place a dipsomaniac under control if he would not voluntarily do so himself.

DR. OWENS asked if there were not some Act to prevent publicans supplying inebriates with alcohol. He had a strong idea that if Dr. Little's suggestions were carried out, half of Queensland would have to be put into this refuge! In a free country like this, would not people look upon any interference as an infringement of the liberty of the subject. However, he thought it would be a good thing if the Legislature could do anything practical in the matter—and if anything were to be suggested, the Legislature would probably ask the Medical Society to put it into shape. With this opinion, he advised the formation of a small committee to obtain information on the subject.

DR. CLOWES asked what the system was in America.

DR. OWENS said the best system was in Canada where a man, if he had means, was compelled to support if he voluntarily gave himself up.

DR. HARE suggested that it would be a step in the right direction to get *delirium tremens* classed as insanity.

After a general conversation, Dr. Little's motion was seconded by DR. LOCKHART GIBSON and carried unanimously.

DR. HILL suggested that a small committee be formed to ascertain what had been done in the other colonies in the matter and to report.

Drs. Taylor, Hill and Little were appointed a committee to enquire into the question.

MONTHLY meeting held on the 15th May, at 8.30 p.m., in the School of Arts, Brisbane. Present—Drs. Thomson (in the chair), Gibson, Clowes, C. Kebbell, Owens, Shout, Hill, and W. S. Byrne.

DR. THOMSON brought forward the following notes of two cases of Rhinolith with specimena. He said, Rhinoliths, or Nasal Calculi are sufficiently rare to be recorded when met with. They are calcareous deposits surrounding a nucleus, which nucleus is usually a solid foreign body from without, but may be a hardened crust of catarrhal mucus from within. Sometimes these stones are developed in the mucous membrane of the nostril, and Erichsen would lead one to suppose that the only cases he has seen were of this kind.

Edward Bellamy, in Quain's Dictionary, speaks very generally and vaguely of these concretions.

Bryant says: "Such cases have been recorded; I have, however, never seen an instance."

Dr. Geo. M. Lefferts, in the fourth volume of Ashurst's Surgery, refers extensively to the literature of the subject and it would seem that M. Demarquay, in a paper on Nasal Calculi published in 1845, had exhausted all that was known about these foreign bodies. Judging from Dr. Lefferts' article it would appear that he had only met with two such cases.

I have removed two Rhinoliths, the one I show you was extracted from the left nostril of a middle aged man some time ago. It weighs 4.15 grammes (about a drachm), measures 1½ inch by 1½, is generally irregular, is apparently a true cast of the turbinated bones and is deposited round a nucleus which looks like the fangs of a tooth, but which, in order to preserve the specimen, I have not disturbed. The concretion was broken across at the time of removal, but the pieces have been cemented.

The second case I had to deal with, the stone had to be crushed and removed piecemeal—lithotripsy was performed. It was much larger and harder than the present specimen and, so far as I could judge, had no nucleus. It was of a greyish blue color not unlike Portland cement, and the patient, who had been for years working with this cement, blamed it for giving rise to the nasal obstruction.

DR. THOMSON also showed a peculiar form of worm forwarded from a patient.

DR. OWENS read notes of a case of Ovariectomy. It was mentioned that Dr. Taylor had had a successful case of Ovariectomy during the month, and that Dr. W. S. Byrne had one on the fair way to recovery.

MONTHLY meeting held on June 12, at 8.30 p.m., in the School of Arts, Brisbane. Present—Drs. Little (in the chair), Tilston, Thomson, Hare, Taylor, W. S. Byrne, Hill, Gibson, Shout and Love.

Dr. Gibson showed a child, with a large Nævus behind the left ear extending forward to beneath the angle of the jaw and beneath the auricle into the external meatus. He purposed to electrolyse it and wished the members to see it before operation so as to be better able to judge of the result of the treatment.

DR. TAYLOR read the notes of a successful case of Ovariectomy, with a specimen of the cyst wall. The operation had proved very simple, the patient not losing more than half an ounce of blood. He referred in terms of high praise to the nurses who had attended the case.

DR. W. S. BYRNE also read the notes of a case of Ovariectomy (which appears elsewhere in our columns), which had been complicated by tough and extensive adhesions. The patient had recovered well after the operation. Dr. Byrne also complimented the same nurses who had nursed Dr. Taylor's case.

DR. LITTLE remarked on the excessive density of the adhesions in Dr. Byrne's case, and had no doubt that the collapse was due to the smart hæmorrhage during the operation. He remarked that the adhesion which had chiefly given rise to the hæmorrhage was firm and round and was for some time mistaken for a ureter. He congratulated Dr. Byrne on his success in a most difficult case.

DR. THOMSON read notes of a case of tumour of the neck, believing that as much was learned from a failure as from a success. The patient suffered intensely from dyspnoea on admission to hospital and tracheotomy was evidently urgently demanded. Some doubt arose as to whether the tumour had originated in the neck or had pushed its way upward from the thorax. The trachea was markedly displaced to the right side, but there was the greatest difficulty in determining its exact site. An incision was made over where the trachea was thought to be and continued deeply into what was taken to be the trachea. A tube was inserted but without relief to the breathing. It was removed and the fingers was pushed into the opening when the breathing improved considerably. The opening was behind the sterno-mastoids and a little above the clavicle. Bleeding was very free. The neck was

bound up and the man seemed relieved. However, he died in a few days and *post mortem* it was found that the incision had been made in the right place but the lumen of the trachea was about four times its normal size. The tumour proved to be a sarcoma of the left lobe of the thyroid.

DR. TAYLOR asked if any of the members present had had any experience of Intubation of Larynx in Diphtheria.

DR. HENRY F. FORBES, M.B., C.M., Aberdeen, of the Brisbane Hospital, was nominated for membership by Drs. W. S. Byrne and F. E. Hare.

The Secretary drew the attention of members to the circulars issued by the Committee of the Intercolonial Medical Congress to be held in Melbourne in January next. It was reported that Drs. Hill and Taylor had received invitations from the Committee to act as Vice-Presidents in the Sections of Gynaecology and Medicine respectively and a hope was expressed that these gentlemen would avail themselves of the opportunity to represent the Society at the Congress.

NEW ZEALAND MEDICAL ASSOCIATION.

As mentioned in our last issue, the Annual Conference of the members of the N. Z. Medical Association commenced on May 30, at 4 p.m., at the rooms of the Y.M.C.A., Wellesley-street, Auckland, Dr. Dawson (president of the local branch) occupying the chair, whilst Dr. Lindsay was secretary. A large number of members of the local branch were present, and the following southern delegates attended the meeting:—Drs. Fell and T. W. Mackenzie (Wellington), Dr. Thomas (Christchurch), and Dr. De Zouche (Dunedin).

THANKS.

DR. DAWSON having delivered the presidential address, Dr. DE ZOUCHE moved a vote of thanks to the President for his welcome to the delegates. The motion was seconded by Dr. THOMAS, and agreed to.

DELEGATES.

Delegates were appointed as follow:—Dr. C. H. Haines, for Canterbury, to act with Dr. Thomas; Dr. MacMullen, Otago; Drs. Hooper and Stockwell, Invercargill; Drs. Walker and Robertson, Nelson.

THE CERTIFYING OF DEATHS.

The question of the non-certifying of deaths in cases where no qualified practitioner had been in attendance, was discussed, and it was resolved, "That this Association is of opinion that in all cases of death occurring without the attendance of a qualified medical practitioner, it shall be incumbent by law on the friends of the deceased, or on the occupier of the house, to report such cases to the coroner, to be dealt with in such manner as he may deem expedient."

INCORPORATION.

The incorporation of the Association was not considered desirable. The consideration of the question of incorporating the Association with the British Medical Association, was deferred until next meeting.

THE NEXT MEETING.

It was decided that the next meeting of the Association be held in Christchurch in the second week in March, 1889.

VACCINATION.

Some discussion took place respecting the increase of the number of public vaccinators in any one district, but it was explained that this matter was in the hands of the Government. It was agreed, "That in the opinion of this Association the Government should be asked to open up a station for the supply of vaccine lymph direct from the calf."

POISON.

The Association resolved, "That the Government be advised to have chlorodyne gazetted as a poison."

SANITARY LAWS.

Dr. E. LEGER ERSON read a paper on "The Sanitary Laws of New Zealand." Some discussion took place at the close of the paper, and it was resolved, "That Dr. Erson be asked to formulate his propositions, and that the matter be referred to the branches, to be reported on at next meeting of the Association in Christchurch."

OTHER PAPERS.

During the session a number of other interesting papers were read, among them one by Dr. MACMULLEN on a remarkable case of "Cirrhosis of the Liver," which will be found in this issue.

MEDICAL ACT AMENDMENT BILL.

During the sitting of the Association a considerable portion of the session was occupied in discussing the provisions of the proposed Medical Act Amendment Bill. The principal amendments are to the following effect:—

A Council to be styled "The General Council of Medical Education and Registration of New Zealand," shall be established.

This Council shall consist of not more than twelve persons, who shall be legally qualified medical practitioners, of whom four shall form a quorum; the term of office of the Council to be five years, and members to be eligible for re-appointment.

The members of the first General Medical Council shall be appointed by the Governor-in-Council, by proclamation in the *New Zealand Gazette*, without previous elections. For the purpose of electing the second and all succeeding Medical Councils the colony shall be divided into four electoral districts, defined as follows:—Auckland electoral district, to comprise the provincial district of Auckland; Wellington electoral district, to comprise the provincial districts of Wellington, Hawke's Bay, Taranaki, Nelson and Marlborough; Canterbury electoral district, to comprise the provincial districts of Canterbury and Westland; and Otago electoral district, to comprise the provincial district of Otago. Each electoral district shall send three members to the General Medical Council.

The duty of the General Medical Council is to draw up each year lists of such universities, colleges, or bodies not in the United Kingdom, the medical diplomas of which the said Council recognise for the time being as furnishing a sufficient guarantee of the possession of the requisite knowledge and skill for the efficient practice of medicine, surgery, and midwifery. Such list shall be furnished by the said Council in each year to the Colonial Secretary for publication in the *New Zealand Gazette*.

All diplomas of all universities, colleges, and bodies in the United Kingdom will be recognised without question by the General Council.

The only person authorised to receive applications for registration is the Registrar-General, who shall

register such persons only as are recognised in the list to be prepared for him by the General Medical Council. The applicant for registration need not apply in person, but may send his diplomas, together with a statutory declaration that he is the person described in the diploma or diplomas; and if the Registrar-General is in doubt about the authenticity of the diplomas it will be lawful for him to summon the applicant to appear in person, and if necessary he shall further confer with the General Council.

Every person whose name is actually on the register of duly qualified medical practitioners of New Zealand on the day of passing of this Act, shall be entitled to have his name placed on the register by the Council under this Act; and every person whose name is on the register of duly qualified practitioners authorised by the General Council of the United Kingdom, and who shall produce to the Registrar-General the document of registration, shall be entitled to be registered.

If any person, whether a registered medical practitioner or not, takes or uses a medical title which he is not entitled to take or use, he shall on summary conviction, be liable to a penalty not exceeding £50 for every such offence. A similar penalty shall be imposed upon any person who, whilst not a registered medical practitioner, represents himself to be such, or uses any name, title, addition, or description implying that he is a registered medical practitioner, or that he is recognised by law as a physician or surgeon, or licentiate in medicine or surgery, or a practitioner in medicine, or an apothecary. If any person who is not a registered practitioner, and who practises in medicine, surgery or midwifery, uses the designation of or represents himself to be a physician, surgeon, doctor, apothecary, professor, specialist, or consultant in medicine, surgery, or midwifery, he shall be liable for every such offence to a penalty not exceeding £50. This clause does not prevent any person using the designation of midwife, or holding a license in midwifery.

WE HAVE just received the first number of *Light*, the new Australian Science Monthly and Literary Review, edited by Mr. John Horrocks and Mr. Walter Roth. An exceedingly interesting and critical paper, by Dr. Ashburton Thompson, on "Milk, Scarlet Fever, and Diseased Cows," deals with the circumstantial and essential evidence which is relied on to support the view that scarlet fever may be communicated by milk, not in the well-known way of infection imparted to it by man after it has left the cow, but as the result of the cow suffering a specific disease at the time of milking, and in consequence yielding a specifically poisonous secretion. Another of our professional brethren, Dr. Roth, has a short article on "Paper Toy-making," the first of a series dealing with some aspects of the Kindergarten system. A careful essay by Mr. Kyngdon Ellis, of Oxford, on the "Characteristics of Australian Poetry," and a contribution by Mr. P. J. Edmunds on "Lightning Conductors," will well repay diligent perusal. Last, but not least, the "Hints to Whist Learners" (part I), the "Art Notes," "Home and Foreign Science Brevities," the reviews of new books, and "Abstracts of Meetings," all help to form an excellent first issue. Should following numbers preserve the same standard, *Light* cannot fail to be a success. It may perhaps be interesting to state that one of the editors, Mr. Roth, a distinguished Oxford science graduate, is at present completing his medical curriculum at the Sydney University.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, JULY 15, 1888.

EDITORIALS.

CLASSIFICATION OF VACCINE SCARS.

THE accurate classification of vaccine scars in connection with attacks of small-pox affords the only means of gauging the protective powers of vaccination against that disease. But as "vaccination" is not an absolute term, but is relative in point of usefulness to the thoroughness of the operation indicated, it is not enough to record in cases of post-vaccinal small-pox merely that the patient has been vaccinated; it is necessary also, to describe the degree of success attained in vaccinating. This is betokened by the appearance of the scars; and it is therefore indispensable to classify these before the significance of the failure of vaccination to protect in particular cases can be learned. Until recently, this classification has generally been done after the scheme devised by Marson, and first published in 1858. He divided his subjects of post-vaccinal small-pox into eight classes; viz., into those who showed one, two, three, or four or more, good or bad scars. This plan was excellent as far as it went; and the tables prepared by it have been of infinite service. But it showed quite clearly, that even good vaccinations protect, not in proportion to their goodness alone, but in proportion also to the area of scarred surface left; and, as is well-known, it has for long been recognised that an area of half a square inch at least is necessary to the best kind of protection. We have already drawn attention to the report presented to the President of the Board of Health by the Chief Medical Inspector, on the outbreak of small-pox on board the mail steamer *Preussen*, which was

published early in 1887. Dr. Ashburton Thompson there exemplified what he thinks may prove a better kind of classification. He resorted to actual measurement of scarred surfaces; and he divided his subjects into four classes as follows: Character of scar good, area of scar sufficient (being the best kind of vaccination); character good, area deficient (being a kind less good than the former, but better than either of the two following); character bad, area sufficient, and character bad, area deficient (being the worst kind); in which "sufficient" and "deficient" mean at least half a square inch, and less than that, respectively. These four classes are set out in four tables divided by ordinate lines, which show which persons were under 15 years, which between 15 and 25, and which were over 25; and by abscissal lines which enable the persons attacked to be distributed into five degrees of severity of illness. Other differences from the usual method are shown in the report to which we refer our readers.

It appears from the sanitary record for February of the present year, that a new method of recording the facts as to vaccination in the case of persons attacked with small-pox has been introduced recently into the hospitals of the Metropolitan Asylums Board, London. Hitherto no other account of the quality of the vaccination of patients has been there taken than consists in the use of the terms "vaccinated," "unvaccinated," and "doubtful." In future, however, the bed-card of each patient is to record—(1) as to vaccination—the statement as to primary vaccination, the number of cicatrices, their collective area, the fractional area of cicatricial surface that can be described as foveated, the number of cicatrices noted as (a) depressed, (b) not depressed, (c) puckered, (d) glazed, (e) not defined in margin; and (2) as to revaccination—its date, and the number and description of cicatrices. The tables to be drawn up from these instructions, it will be seen, will very closely resemble those of Dr. Ashburton Thompson to which we have drawn attention above. That gentleman is to read a paper before the Australian Association for the Advancement of Science in September next, in which he will probably explain the steps by which he arrived at his classification; in the meantime we understand that he regards many of the requirements of the Metropolitan Asylums Board's instructions as impracticable. This matter is one of great and general importance; and medical members of the Association (to which we wish all success) should attend the section of Preventive Medicine prepared to discuss it thoroughly.

THE QUESTION OF REGISTRATION OF AN AMERICAN DIPLOMA IN SOUTH AUSTRALIA.

We desire to express our sympathy with the Medical Board of South Australia in the very difficult position in which it is placed with reference to the registration of a graduate of the Hahnemann Medical College of Chicago, Ill., as reported in the June number of the *A. M. Gazette*. We think the Board would not be justified in registering a diploma against its judgment, on the mere opinion of the Attorney-General and Crown Solicitor, for it must not be forgotten, that the only recognised interpreter of the law of any country is the Supreme Court, and the Board should act on its decision only. Having carefully studied all the facts of the case in dispute, and having also before us the Acts relating to the practice of Medicine and Surgery in the State of Illinois, we are of opinion that the applicant has no claim to registration on the ground that his diploma would entitle him to practice in that State. We find that according to an Act which came in force on July 1, 1877, registration by the State Board of Health is the only authority under which any man can practise in Illinois, and that such registration is not granted to the possessor of any diploma who has not acquired it after due examination, undergone subsequent to two full courses of medical study of not less than 20 weeks each, and that these two courses must not have been gone through in one and the same year of time. As it is stated that the applicant was only from 12 to 14 months absent from South Australia, it is evident that he did not comply with the above condition and that therefore his diploma would not have been registered in Illinois, and he could not practise in that State. We think that the Medical Boards of Australasia should demand that an applicant shall produce an authority, entitling him to practise in the State in which his diploma was obtained, and that, failing its production, the applicant cannot be legally registered. As the only authority to practise in the State of Illinois is the certificate of the State Board of Health, we are of opinion that the Applicant should be referred to that Board and failing the granting of its certificate he should not be registered in South Australia.

We have also carefully examined the Official Register of Physicians to whom certificates have been issued by the State Board of Health of Illinois between 1877 and 1886, but cannot find Mr. Bollen's name in it. We would suggest that if any doubt continues to exist, that the Board should communicate with Dr. John H. Ranch,

the Secretary of the Illinois State Board of Health, in Springfield, Ill., U.S.A., before registering the applicant.

TYPHOID FEVER IN SYDNEY AND SUBURBS.

(FROM 1876 TO 1888.)

THE subjoined statement has been issued by the New South Wales Board of Health. The diminution noted in the number of cases of typhoid fever, which has taken place is a subject for congratulation, but we fear that unless a Public Health Act is quickly passed this improvement will hardly prove permanent. The tables accompanying it are most lucid, and we regret that we cannot spare the space to reproduce them, which, however, is hardly necessary in view of the careful analysis of their contents given by the Secretary of the Board in his report.

The following is the statement referred to:—

"In table I. a statement is given of the number of deaths in each month of the ten years ending 31st December, 1885, together with the ratio calculated per 100,000 of the population, as estimated on the 30th June in each year. From this it will be seen that during the decennial period there was a very large increase in the mortality from this disease, namely, from 46·07 per 100,000 in 1876 to 102·17 in 1885.

"Table II., gives a similar statement for 1886 and 1887, and for the first five months of 1888, the ratio in the latter being calculated as per 100,000 of the population estimated on the 1st January. From this latter table it will appear that the mortality from typhoid fever has of late undergone considerable and progressive diminution—thus: In 1886 the rate per 100,000 was 90·90; in 1887 it was 58·11; and the ratio for the five months of 1888 is greatly below that for the corresponding period in the two previous years, being only 30·97 as against 38·16 in 1887 and 62·17 in 1886.

"The inference from these figures, that typhoid fever has been diminishing in prevalence during the period embraced by table II., is confirmed by the results of table III., which contains a return of the number of cases of typhoid fever admitted to the Metropolitan Hospitals of Sydney, and of the number of deaths which have occurred in these institutions during 1886, 1887, and the first five months of 1888. From this it appears, in 1886, there were 809 cases admitted, with 124 deaths; in 1887 there were 598 cases, with 84 deaths. In the first five months of 1888, which is the heaviest portion of the year for this

disease, the number of admissions were 423, with 54 deaths; the corresponding period in 1886 shows 537 admissions, with 85 deaths; and in 1887, 486 admissions, with 64 deaths.

"The period under consideration (since 1886) is of course too short to enable us to form an absolute conclusion as to whether the prevalence of the disease is likely to become permanently less; but it is evident that at all events for the present an improvement has taken place, and from the diminution in the death-rate, it would appear that the severity of the disease has also somewhat lessened.

"The Board would draw the attention of the Colonial Secretary to the very great amount of work which has been done by the Coast Hospital in connection with typhoid fever in this city. Of a total of 1,830, as shown in table III., no fewer than 843 have been treated at Little Bay, and it will be seen that the death-rate compares favorably with that of any of the other institutions.

"The Board would, lastly, urge upon the Colonial Secretary the very great importance of this matter. Typhoid fever is essentially a preventable disease, and makes its ravages chiefly among the younger and more vigorous members of the community. By well-concerted sanitary measures the prevalence of the disease can be very greatly reduced, and much sickness and death may be spared to the community. But for this purpose the Board is of opinion that a Public Health Act is required."

LETTERS TO THE EDITOR.

THE CASE OF J. G. A. ZIEHLKE.

(To the Editor of the A. M. Gazette.)

SIR,—My attention has been called to a statement appearing in your issue of the 15th ult., that a person named Julius Gustav Adolph Ziehlke had been registered in South Australia as a legally qualified medical practitioner. As the Secretary of the Medical Board, I feel it my duty to inform you that this statement has no foundation in fact, and that the name in question has never appeared on our register.

Yours truly,

S. K. ELLISON,
Hon. Sec. S. A. Med. Board.

Adelaide, June 11, 1888.

[The statement referred to by our correspondent appeared in the letter addressed by the Secretary of the Maytown Hospital to the President of the Queensland Medical Board, which we published in our editorial, entitled, "Praiseworthy action of the Queensland Medical Board," in the May number of the A. M. Gazette. We ourselves were fully aware of the fact that the said person had never been registered by the South Australian Medical Board.—ED. A. M. G.]

SIMPLE FRACTURE OF THE UNGUAL PHALANX OF THE MIDDLE FINGER.

(To the Editor of the A. M. Gazette).

SIR,—Erichsen in his "Science and Art of Surgery" (7th edition), says: "I do not think that simple dislocation of the *ungual phalanx from the second* is possible." A short time ago this accident happened to me while I was playing cricket. I attempted to stop a ball while fielding at "mid-off," that was hit with all the batsman's might. I saved a run, but on looking at my middle finger I discovered that its unguinal phalanx was quite out of its natural position. I immediately and without difficulty reduced the dislocation, and heard or felt a decided snap. Although the accident happened two months ago, any unusual effort of the finger is still attended with some discomfort.—Yours truly,

A. G. E. NAYLOR, L.R.C.P. & S., Edin.,
Swansea, Tasmania, June 26, 1888.

HOW THE GOVERNMENT MEDICAL OFFICERS ARE TREATED IN THE COUNTRY.

(To the Editor of the A. M. Gazette.)

SIR,—Being subpoenaed as a witness by the Crown in the case of Queen v. Carter, for rape on daughter, I had to proceed to Grafton, to attend the Assize Court held there on the 20th April last. As the distance from here to Grafton is 161 miles, I had to leave here on the 16th inst., in order to arrive there in time, having to drive sixty miles in my own buggy, and doing the rest of the journey by coach and steamer. I was detained at Grafton for four days, and altogether I was compelled to be absent from my practice here for eleven days. During that time, as I held several medical appointments, including Oddfellows' Lodge, I was obliged to find a *locum tenens* for them, and lost a considerable amount of private practice by being absent so long. Now, sir, I find all I am allowed by the Government for this compulsory absence from my business, and journey of 322 miles, is one guinea per diem for eleven days, one guinea for my evidence, and the usual travelling expenses of a witness for the journey, one way only. I need scarcely say that after paying my *locum tenens* and travelling expenses, I am largely out of pocket by the transaction. On being appointed Government Medical Officer for this district, I received from the Colonial Secretary's office a copy of the regulations affecting attendance by medical men at the request of the police and the medical department, in which there is a table of fees payable for medical attendance up to 25 miles—the mileage allowed for that distance being £8—cases occurring above 25 miles the regulations state are to be submitted for the determination of the medical adviser to the Government. I accordingly wrote, submitting the matter to him, and received a reply stating "This matter rests entirely in the hands of the Crown Solicitor, and this office has no control over it." In reply to my letter, stating the case fully, and requesting some extra allowance for the inconvenience and loss I had been put to, I am informed by the Crown Solicitor that "it cannot be entertained."

Now, sir, I consider such treatment by the Government is a decided injustice to any medical man. The appointment of Government Medical Officer is entirely paid by fees, and, as it is, the mileage allowed by Government in outlying districts, where there are neither railways or coaches, and bush roads are notoriously bad, is only one half that usually paid in private practice. If a medical man is to be dragged away from his practice as I have been, and compelled under a penalty of £100 to take a journey of over 300 miles, to

further the ends of justice, surely he is at least entitled to something like fair compensation for the enforced absence from his practice and consequent pecuniary loss. As this is a matter affecting all medical men, more especially those practising in outlying bush districts, to whom the same hardship might occur at any time, I think it is worthy of being ventilated in your columns.—I am, &c,

A. FORBES, L.R.C.P. ED., L.R.C.S.I.
Murwillumbah, Tweed River, N.S.W., June 30.

THE MONTH.

FIJI.

A NUMBER of the civil servants assembled at the Supreme Courthouse, Suva, on June 5, to present an address and a purse of sovereigns to the Hon. Dr. W. McGregor, C.M.G., on the eve of his leaving by the Tenterden for Australia, where he is to await instructions from Her Majesty's Government with reference to his appointment over British New Guinea. The address was of a most kindly and eulogistic nature, and was accompanied by a sum of money to be converted into some souvenir that would serve to remind Dr. McGregor of the civil service of Fiji. The residents of Suva and the surrounding districts also presented an address. At the monthly meeting of the Legislative Council, which was held on the same day, a motion was passed in which the Legislative Council desired to place on record their high appreciation of the long and valuable services rendered by him to the colony in his capacity as a member of the Council, and as one of the chief advisers of the Government.

NEW SOUTH WALES.

AT a recent meeting of the Council of the University of Sydney, a letter was received from Dr. A. M'Cormick, resigning his office of Demonstrator in Physiology from the end of the year. It was resolved, on the motion of Professor Stuart, "That the resignation be accepted," and the Registrar was instructed to express to Dr. M'Cormick the Senate's regret at the loss of his services. A memorandum was received from Professor Stuart suggesting that the selection of a gentleman to fill the vacancy should be left in the hands of Dr. Michael Foster, Professor of Physiology in the University of Cambridge and Secretary of the Royal Society of London, and proposing certain conditions of office. The proposals contained in Professor Stuart's memorandum were adopted.

MR. BRUCK'S "Guide to the Health Resorts in Australia, Tasmania, and New Zealand," which has been highly spoken of by the press throughout the colonies, is recommended, in the Calendar of the University of Sydney for 1888, as a book of reference to the medical students attending the lectures on *Materia Medica* and *Therapeutics*.

MRS. GUILLE, holder of the military red cross, who has been matron of the Goulburn Hospital for the last four years, and who was matron of the Little Bay Coast Hospital, near Sydney, during the small-pox epidemic, has just opened at Goulburn "The Dora Nursing and Convalescent Home," for the reception of surgical, medical, and midwifery cases.

MISS MUNRO, who has been connected with the Nurses' Home in Sydney for the last five years, has just

been appointed Matron of the Goulburn Hospital, in the place of Mrs. Guille, resigned.

DR. H. L. BARKER has commenced practice at Dubbo.

DR. P. P. BRENNEMAN, who till lately practised at Newtown, near Sydney, in conjunction with Dr. Kingsbury, has commenced practice on his own account at 223 Macquarie Street, Sydney.

DR. HAROLD BROWNE has commenced practice at Summer Hill, a suburb of Sydney, in conjunction with Dr. D. Collingwood.

DR. L. G. DAVIDSON, late of Balmain, and formerly of Goulburn, has succeeded to the practice of the late Dr. L. C. Jockel, at Richmond.

DR. L. G. DAVIDSON, junr., has succeeded to the practice of Dr. W. McMurray, at Walgett, in a pastoral district, 450 miles N.W. of Sydney.

DR. LOUIS FITZPATRICK, J.P., of Queanbeyan, who is leaving the district, was, on June 21, entertained at dinner by a number of leading residents, and was subsequently presented by Mr. J. J. Wright, J.P., ex-Mayor of Queanbeyan, with a handsome gold hunting lever watch, subscribed for by his friends.

DR. MACLAURIN has resigned his position as a member and President of the Rabbit Commission, through lack of time to devote to the work.

DR. P. H. METCALFE, of Norfolk Island, has gone to England on a visit.

DR. F. A. POCKLEY, of North Shore, near Sydney, has been admitted *ad eundem gradum* to the degrees of M.B. et Ch.M. of the University of Sydney.

DR. C. H. J. SOUTER, junr., who lately practised at Binger in conjunction with Dr. J. C. Souter, sen., has removed to Hillston, on the Lachlan River, he having been appointed Medical Officer of the local Hospital.

DR. H. W. SWAYNE, of Tenterfield, has been appointed a Coroner for the colony generally.

NEW ZEALAND.

In the House of Representatives, on May 31, Sir George Grey moved the second reading of the Repeal Bill of the "Contagious Diseases Act, 1869." Dr. Hodgkinson supported it, and Messrs. Levestam, Pyke, and Taylor opposed the Bill. Messrs. Fulton, Goldie, Hobbs, Buxton, and Moss urged the House to pass the measure, but eventually the motion for the second reading was lost by 30 to 27 votes.

A RETURN of persons drowned in New Zealand rivers from the foundation of the colony, shows that 2,236 lives have been lost in this way.

ON Tuesday, June 19, as Dr. Jas. Galbraith, of Invercargill, was passing along the street in North Invercargill, a man named John Maloney, inspector of nuisances for the borough, followed the doctor with a double-barrelled gun, and deliberately fired at him. Dr. Galbraith was severely wounded in the thigh, the leg from the hip to the knee being riddled with a heavy charge of shot. He fell to the ground, and Maloney walked away. The doctor was put into a passing trap and brought to his residence in town, where several colleagues who had assembled attended to his injuries. Dr. Galbraith is an elderly man, and is suffering from the shock to the system. The man Maloney was arrested, and on the way to the lockup he talked inconsistently of the outrage, which is supposed to be the out-

come of an insane grudge against the medical profession. Dr. Galbraith has had no dealing with Maloney for years. The latter suffers from a chronic disease, and about five years ago he sued Dr. Cotterell in the Supreme Court for damages for alleged maltreatment. The action broke down, and the question of Maloney's sanity was afterwards raised, he having stated he would "wing" Dr. Cotterell. Dr. Galbraith, with other medical men, declined to certify that he was insane, and Maloney seems to have harbored a grudge against him and the other doctors since.

QUEENSLAND.

TYPHOID fever and diphtheria have lately been prevalent at Hughenden.

DR. A. R. BROOM, late of Goondiwindi, has settled at Eidsvold, 65 miles from Gayndah.

DR. W. McMURRAY, late of Walgett (N.S.W.), has settled at Muttaborra, the centre of a large pastoral district, 850 miles N.W. of Brisbane. Dr. McMurray has been appointed Surgeon of the Hospital at Muttaborra.

DR. F. H. VOSS has been appointed to be Inspector of Pacific Islanders and Laborers at Rockhampton. In the room of Dr. W. F. Thurston, resigned.

SOUTH AUSTRALIA.

At a recent meeting of the South Australian Board of Health, the present insanitary condition of Broken Hill (N.S.W.) was discussed, and it was resolved that owing to the large number of heads of South Australian families who have taken up their residence at Broken Hill, and to the many cases of typhoid fever which are brought from that district and distributed in different parts of South Australia, representation be made to the Government requesting them to communicate with the New South Wales Government, and to urge that more efficient sanitary regulations be adopted in the Barrier District.

At a meeting of the Directors of the Agricultural Bureau, held in Adelaide on June 18, the Acting Secretary reported that he had called upon certain importing and manufacturing druggists with respect to the probabilities of a market for scents or perfumes extracted by the "enfleurage" process, also for medicinal herbs, roots, &c., and that he had been informed that there would be no sale locally for such products—probably neither for export nor for local use. Sir Samuel Davenport suggested that it was desirable to make enquiry of the Agent-General (through the Chief Secretary) as to the prospects of a market in Europe for drugs, and also for scents, or for the scented fats.

DR. O. L. M. ABRAMOWSKI has resigned his appointment of Surgeon in the South Australian Volunteer Force.

DR. R. McDougall, formerly of Murrumburrah and Glen Innes (N.S.W.), has commenced practice at Gladstone, 134 miles N. of Adelaide.

DR. W. A. B. POTTS, formerly of Willesden, London, and late of Broken Hill (N.S.W.), has settled at Border Town, near the Victorian border, 282 miles S.E. of Adelaide.

DR. R. ROBERTSON, of Adelaide, has resigned his appointment as a Public Vaccinator.

TASMANIA.

DR. L. S. HOLMES has removed from Moorina to Launceston, where he is practising in conjunction with Dr. W. R. Stewart.

DR. H. G. H. NAYLOR has removed from Campbelltown to Launceston.

VICTORIA.

THE Council of the University of Melbourne have granted the use of the Wilson Hall and any other rooms in the University that might be available for the purpose of holding the sittings of the second Australasian Medical Congress, commencing on Monday, January 7, 1889, and ending on January 12.

At a recent meeting of the Central Board of Health the President reported that the P. and O. Co.'s R.M.S.S. "Britannia" arrived at Melbourne on her last trip without a clean bill of health from Albany, owing to the newly-appointed officer of that port having demanded a guinea for the document, which the captain refused to pay. The Board resolved to write to the authorities to learn whether the Health Officer was authorised to charge for bills of health.

DR. WOLFENDEN, of St. Arnaud, was sued in the local County Court, on June 27, before Judge Hamilton and a jury of six, by a Mr. Swinnerton, who tried to recover £500 damages for assault. The plaintiff, who is described as a clerk in holy orders, was a patient in the St. Arnaud Hospital, when the defendant, the Resident Surgeon, committed the assault which was the subject of the action. The assault was admitted, and £5 was paid into Court as full compensation. The jury adopted this view of the case, and returned a verdict for £5.

THE University of Glasgow has conferred the degree of Doctor of Medicine upon Mr. Robert Denham Pincock, M.B., C.M., of Ballarat, for his thesis on "The history and progress of ovariectomy in the Australian colonies."

DR. W. L. WATKINS, Medical Superintendent of the Sunbury Lunatic Asylum, has been appointed to be Medical Superintendent of the Yarra Bend Asylum, vice Dr. T. T. Dick, relieved, and Dr. J. A. O'Brien, a Senior Deputy Medical Superintendent, has been appointed Medical Superintendent of the Sunbury Asylum, vice Dr. W. L. Watkins, transferred.

MR. JOHN HARRY HAMILTON, L.R.C.P. Lond., 1882, L. et L. Mid. R.C.S. Edin., 1880, late of Kensington, London, died at Marli-place, Esplanade, St. Kilda, Melbourne, on June 7, aged 33 years.

MR. CALEB RADFORD, L.S.A., Lond., 1834; M., 1835, F., 1847, R.C.S., Eng., who for many years practised at Merino, died at Sandford on June 29. The deceased gentleman was a colonist of 26 years' standing.

DR. A. W. EDDIE has removed from Bombala (N.S.W.) to Winchelsea, on the Barwon River, 71 miles S.W. of Melbourne.

DR. CHAS. FETHERSTONHAUGH, late of Colac, is now practising at North Melbourne.

DR. J. F. JOYCE, of Fitzroy (Melbourne), has been unanimously elected Honorary Surgeon of the Fitzroy Temperance Fire Brigade.

DR. OLIVER PENFOLD has been re-elected as President of the Sandhurst Liedertafel.

DR. THOS. ORDE SMITH, a new arrival, has commenced practice at Echuca.

HOSPITAL INTELLIGENCE.

THE annual report of the Adelaide Hospital Board shows that the number of patients admitted during the year 1887 was 1,895; the average daily number of patients in the hospital was 172; the average number of day-patients discharged was 32. The number of deaths of in-patients was 144, 12 of which occurred within twenty-four hours of admission, and 4 within seven days of admission. During the past year there have been 439 operations performed, of which 402 proved successful, 5 were unsuccessful, 15 patients were relieved, and 17 died. Mr. J. R. Gurner, L.D.S., Honorary Dentist to the hospital, has attended 414 cases of dentistry. The number of attendances of out-patients treated during the year was 10,554. The return of prescriptions made up for other departments during the year is as follows, viz.:—Destitute Asylum, 7,519; Lunatic Asylum, 2,205; Adelaide Gaol, 1,897; total, 11,621. The annual cost of each in-patient during the year was £51 16s 10d.

SOME contagious diseases wards in connection with the Hospital at Hay (N.S.W.), are now being erected.

THE new Cottage Hospital at North Shore, near Sydney, was formally opened on June 18. For the present, however, accident cases only will be admitted.

THE number of patients treated at the Herberton and Tinaroo (Q.), district hospital during the first six months of this year has been 109.

DURING an interview with the managers of the Alfred Hospital, Melbourne, Dr. Embling, the Chairman of the Hon. Medical Staff, explained that since the establishment of the clinical school some difficulty had been experienced with regard to the administration of chloroform during operations on Tuesdays, the members of the staff who lectured in the morning being unable to attend operations in the afternoon. It was therefore resolved that, in order to obviate the difficulty, Dr. Travers should be appointed Hon. Chloroformist, he being willing to accept the office. To this the managers agreed. Dr. Embling also pointed out that more accommodation was required for the specialists, they having at present to treat their patients in a mixed ward, particularly inconvenient in the case of eye, ear, throat, and skin diseases.

AT a special meeting of the Committee of the Melbourne Women's Hospital, held to consider the question of management in the Genevieve Ward wing, which would shortly be opened, it was decided, on the motion of Dr. Jamieson, "That the institution be divided into two departments—the infirmary and lying-in—each with its medical officer who would be responsible for it, and who would receive a salary of £200 per annum; the positions to be offered to the present officers in the institution."

A LETTER has been received by the Committee of the Women's Hospital, Melbourne, from Dr. Balls-Headley, who stated, on behalf of the Honorary Medical Staff of the infirmary and midwifery departments, that at a meeting they had resolved that the action of the Committee in appropriating the students' fees for the institution would deprive the students of that instruction for which the fees were paid, and was without precedent in this city or elsewhere. The Medical Staff, therefore, recommended that the regulation be altered without delay. The letter was not discussed.

THE sum of £1,006 has been bequeathed to the Melbourne Women's Hospital under the will of the late Mrs. Charlotte Johnston.

DRS. E. W. ANDERSON and R. H. J. FETHERSTON, of the Melbourne Women's Hospital, have accepted the positions of medical officers of the infirmary and midwifery departments, which, in accordance with a resolution passed at a recent meeting of the Board of Directors, were offered them as present officers of the institution before being opened to competition.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Garrett, William Fry, L.R.C.P. Edin., 1887; L.R.C.S. Edin., 1887; L.F.P.S. Glasg., 1887.
Bennet, Francis Alexander, M.B. & M.S. Univ. Aberd., 1884.
Harvey, John Thomas, M.B. & M.S. Univ. Edin., 1886; M.R.C.S. Eng., 1888.
Martin, John Wilson, M.B. & M.S. Univ. Edin., 1887; L.R.C.P. Edin., 1887; L.F.P.S. Glasg., 1887; L.R.C.S. Edin., 1887.
Perkins, Alfred Edward, M.B. Univ. Sydney, 1888.
Barker, Herbert Llewellyn, M.B. & M.S. Univ. Edin., 1887.
Browne, Harold, M.R.C.S. Eng., 1886; L.R.C.P. Lond., 1886.
Hawthorne, Alfred Wynter, M.D. & M.Ch. Royal Univ. Irel., 1882; L.M.D. K.Q.C.P. Irel., 1882.
Hume, John, M.B. & M.S. Univ. Edin., 1884.

SOUTH AUSTRALIA.

Larmite, Charles Gower, M.R.C.S. Eng. & L.S.A. Lond., 1886.
McDougall, Richard, M.D. 1882, M.B. & Ch.M. 1873, Glas.

TASMANIA.

Cookson, Reginald George, L.R.C.P. Lond., 1887.

VICTORIA.

Westbrook, Richard Talbot, M.R.C.S. Eng., 1887; L.A.H. Dubl., 1887.
Smith, Thomas Orde, M.B., 1878, Ch.B., 1879, Dubl.; L.M.D. K.Q.C.P. Irel., 1878.

Additional qualification registered:—

Dalsh, William C., M.D. Melb., 1888.

MEDICAL APPOINTMENTS.

Bewes, Edward Austis, L.R.C.P. Edin., M.R.C.S.E., to be Public Vaccinator for the district of Auckland, N.Z.
Broom, Arthur Robert, M.R.C.S.E., L.R.C.P. Edin., to be Government Medical Officer at Eidsfold, Qu.
Cox, James Wharton, M.B. & Ch.B. Edin., to be a Public Vaccinator for the district of Gore, N.Z.
Cuppelidge, John Loftus, M.D. & Ch.B. Dubl., to be Government Medical Officer at Roma, Qu., vice Dr. G. Comyn, resigned.
Eddie, Arthur William, M.B. & Ch.M. Aberd., to be Public Vaccinator at Winchelsea, Vic.
Evans, Owen Spencer, M.R.C.S.E., to be Visiting Surgeon to the Goal at Biloela, near Sydney.
Gormley, John William, L.R.C.S.I., L.K.Q.C.P. Irel., to be Health Officer for the district of Gould's Country, Tasmania.
Henry, Arthur Geddes, M.B. Syd., appointed Resident Medical Officer at the Prince Alfred Hospital, Sydney, vice Dr. F. Bancroft, resigned.
Kesteven, Leighton, M.R.C.S.E., to be Government Medical Officer at Brisbane, vice Dr. W. Hobbs, retired.
McDougall, Richard, M.D. & Ch.M. Glas., to be Public Vaccinator at Gladstone, S.A.
Mullen, William Lowell, M.B. & Ch.B. Melb., to be a Junior Deputy Medical Superintendent, Hospitals for the Insane in Victoria.
Mullins, George Lane, B.A., M.B. Trin. Coll. Dubl., appointed Medical Officer of the Out-Patient's Department at St. Vincent Hospital, Sydney.
O'Neill, John, M.D. Edin., to be Public Vaccinator at Maldon, Vic., vice Dr. A. J. Farr, resigned.
Richardson, Arthur, M.D., M.R.C.S.E., L.R.C.P. Ed., to be Public Vaccinator at Ororoo, S.A.
Waters, Clarence Henry, M.B. & Ch.M. Edin., to be Public Vaccinator at Rosedale, Vic., vice Dr. G. A. Walpole, resigned.

BIRTHS, MARRIAGES, AND DEATHS.

. The charge for inserting announcements of Births, Marriages, and Deaths is 2s. 6d., which should be forwarded in stamps with the announcement.

BIRTHS.

ALSOP.—On the 27th June, at Upper Hawthorn, near Melbourne, the wife of T. O. Fabian Alsop, M.B., C.M. Edin., M.R.C.S., of a son.
EMBLING.—On the 26th June, at Rheola, Power-street, Hawthorn, Melbourne, the wife of Dr. H. A. Embling of a daughter.
MATHESON.—June 7, at Waverley, Sydney, the wife of M. Matheson, M.D., of a daughter.
O'NEILL.—On the 4th July, at Maldon, Victoria, the wife of John O'Neill, M.D., of a son.
RUTLEDGE.—June 13, at 407 Riley Street, Surry Hills, Sydney the wife of the Rev. D. D. Rutledge, M.A., M.B., Ch.M., of a son.
THANE.—June 17, at Yass, N.S. Wales, the wife of P. T. Thane, L.R.C.P. Lond., M.R.C.S. Eng., of a son.
WALL.—On the 6th June, at Colac, Victoria, the wife of Max Wall, M.D., of a daughter.

MARRIAGES.

BRETT—TELFORD.—On the 5th June, at Brighton, Victoria, by the Rev. J. Hay, John Talbot Brett, L.R.C.P. Lond., M.R.C.S. Eng., of Collins Street East, Melbourne, eldest son of the late John Brett, M.D., Deputy Surgeon-General H.M. Indian Army, to Margaret Stirling Telford, third daughter of the late James Campbell Telford, M.D., of Cobran, Deniliquin, N.S.W.
CLAY—HESTER.—At Kimo, Gundagai, N.S.W., on June 28, by the Rev. R. J. R. Edwards, William Rudolph Clay, M.R.C.S., L.R.C.P. Lond., of Rockdale, near Sydney, eldest son of the Rev. W. French Clay, M.A., M.D., late of the Indian Medical Service, to Rosa Catherine, eldest daughter of the late James Hester, M.D., Indian Medical Service, and stepdaughter of J. F. Waller, Esq., Sydney.
LANE—CREELMAN.—On the 21st June, at All Souls' Church, East Adelaide, by the Rev. R. Kenny, M.A., George Thomas Lane, of Sunnymede, Fullarton, only son of George Lane, of Shrublands, Kent Town, to Harriett Euphemia, only daughter of J. A. Creelman, M.R.C.S.E., late of Quorn.
RYAN—LEYDIN.—On the 6th June, at St. Patrick's Cathedral, Melbourne, Timothy Bernard Ryan, M.B., Ch.B., of Clifton Hill, Melbourne, to Maria Ellen Clare, fourth daughter of John B. Leydin, Esq., of Carlton.

DEATH.

GOSSE.—On the 2nd June, at Delamere Station, Northern Territory Henry, third son of the late William Gosse, M.D., aged 40 years.

Medical Books at PUBLISHED Prices.

MR. BRUCK, Medical Bookseller in Sydney, begs to inform the profession that he is selling all medical books at PUBLISHED prices. An assortment of the latest works has just been received by the Orient S.S. "Iberia." A list of some of the books in stock, with published prices attached, will be found in this issue.

MR. BRUCK, of 35 Castlereagh Street, Sydney, has received a full supply of URINARY TEST TABLET CASES, consisting of nest of test tubes, 6 sp. gr. beads, graduated pipette, litmus papers, and 9 tubes of test tablets, such as citric acid, lead oxide, sodium carba., bismuth, subnit., indigo, iodide, ferrocyanide, &c., with directions, complete in case. Price 12s 6d, postage 1s 6d. Also, Parke, Davis, & Co.'s Nickel-plated Hypodermic Pocket Cases, complete, 16s. 6d.

MR. BRUCK has also for sale a very fine Army Regulation Case (by Weiss, London) in mahogany, brass bound, with tray, and lined with velvet. Price, £12 10s.

REPORTED MORTALITY FOR THE MONTH OF MAY, 1888.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Group and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Cancer.	Child-bearing.
N. S. WALES														
Sydney	132,846	845	194	76	2	2	4	...	7	11	19	22	6	1
Suburbs	215,849	860	333	175	5	4	20	...	14	14	30	26	6	1
*NEW ZEALAND.														
Auckland	35,965	83	39	17	...	...	1	...	3	5	2	2	2	...
Christchurch	16,217	89	11	2	...	...	...	...	...	1	...	3	1	1
Dunedin	24,334	40	38	8	...	...	...	1	1	2	3	4	3	1
Wellington	28,235	84	40	18	...	...	2	...	3	5	2	4	2	...
QUEENSLAND.														
Brisbane	51,689	201	65	26	}	...	4	...	4	9	5	8	2	2
Suburbs	21,960	103	30	13										
SOUTH AUSTRALIA.														
Adelaide	314,949	1,002	374	128	...	1	28	...	22	21	34	31	10	3
Adelaide	43,527	109	80	18	...	...	6	...	10	1	10	6	4	...
TASMANIA.														
Hobart	32,047	104	61	11	...	...	2	...	4	2	7	3	2	1
Launceston	20,112	59	44	8	...	...	1	...	5	...	...	5	1	...
Country Districts	88,588	256	77	...	...	...	4	...	1	1	...	...	...	...
VICTORIA.														
Melbourne	69,774	153	88	} 242	...	...	36	...	32	12	65	41	19	6
Suburbs	275,606	1,173	573											

METEOROLOGICAL OBSERVATIONS FOR MAY, 1888.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum	Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.		Depth.	Days.		
Adelaide—Lat. 34° 55' 33" S. ; Long. 138° 36' E. ....	...	84	58	39.8	30.053	...	Inches	...	...	...
*Auckland—Lat. 36° 50' 1" S. ; Long. 174° 49' 2" E.	130	73	58.7	43	...	...	...	9	74	...
Brisbane—Lat. 27° 28' 3" S. ; Long. 153° 16' 15" E.	140.8	78.8	62.6	43.5	30.179	1.156	8	75	s.	...
*Christchurch—Lat. 43° 32' 16" S. ; Long. 172° 38' 59" E.	143	78.6	51.5	31.2	...	3.255	9	74	...	...
Dunedin—Lat. 45° 52' 11" S. ; Long. 170° 31' 11" E. ....	...	...	...	...	...	...	...	...	...	...
Hobart—Lat. 42° 53' 32" S. ; Long. 147° 22' 20" E. ....	...	75.3	50.4	35.2	30.044	1.25	12	86	...	...
Launceston—Lat. 41° 30' S. ; Long. 147° 14' E. ....	...	74.5	51.1	30	30.116	1.93	10	79	...	...
Melbourne—Lat. 37° 49' 54" S. ; Long. 144° 58' 42" E. ....	...	78.1	53.6	40	30.099	3.77	15	...	...	...
Sydney—Lat. 33° 51' 41" S. ; Long. 151° 11' 49" E. ....	...	72.1	56.7	42.6	30.187	0.55	9	75	w.	...
*Wellington—Lat. 41° 16' 25" S. ; Long. 174° 47' 25" E.	125	67.9	54.5	42.8	...	4.053	13	82	...	...

* The Statistics for New Zealand are those of the preceding month.

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

NOTES ON CLEFT PALATE AND ITS TREATMENT.

By CHARLES W. MACCARTHY, M.D., F.R.C.S.I.,
M.K. AND Q.C.P.I., Hon. Surgeon to St.
VINCENT'S HOSPITAL, SYDNEY, &c.

As the propriety of operating in any given case is, or ought to be, in a great measure determinable by the consideration of the results obtained by operation in similar cases, it is clearly incumbent on surgeons in recording special operations undertaken by them, to state their results, immediate and remote, whether satisfactory or otherwise. In this spirit I publish the following cases with appended remarks.

Some years ago, while practising in Clonmel, Ireland, I operated for cleft soft palate on a lady then in her twentieth year. The operation was done without chloroform, the patient giving every assistance, anxious to derive benefit, though made aware of the doubtful issue of the undertaking. The edges were pared, sutures passed, muscles paralysed, stitches clamped—all steps of the operation gone through satisfactorily. Union, as perfect and as extensive as I have ever seen in such cases, was obtained in due time, and some of my colleagues, to whom I showed the case when union had taken place, pronounced the operation to have been completely successful. The patient, who lived a considerable distance from town, was accordingly discharged with the assurance that, as far as the surgeon's part was concerned, nothing was left to be desired; that henceforth it rested with herself to achieve the object for which the operation was undertaken. I therefore admonished her to educate herself daily in the pronunciation of words, explaining, as I did prior to the operation, that the mere removal of an abnormality which had been present since birth, could not be supposed *per se* to correct the life-long habit of mal-pronunciation; that though the cause was removed, the habit still remained, and needed, on her part, continued and judicious correction. This she quite understood, and promised to educate her pronunciatory powers by slowly reading and speaking aloud.

Five years passed, during which I completely lost sight of her. Meanwhile, a medical friend, Dr. O'Brien, then of Bansha, County Tipperary, brought to me another cleft palate case for operation, a girl aged thirteen years—soft palate only affected. Fluids returned through the nose in swallowing, and pronunciation was very defective.

No chloroform was administered. The operation was performed in the usual way, but unfortunately, owing to want of attention to my injunctions, the stitches gave way on the third day. The edges, however, were again pared and brought together, and partial union was obtained.

Before speaking of the ultimate results in both of these cases, I shall make a few remarks on the steps of the operation. In neither instance, as we have seen, was chloroform administered, no gag was employed, nor did I make use of any local anæsthetic. The days of cocaine had not yet come, else I should have employed that most valuable drug. As sutures, I used fine carbolized catgut. The muscles were paralysed by their division at the same sitting. I had no difficulty in introducing the sutures by means of the bent tubular needle, which is vastly preferable, in my opinion, to the cork-screw pattern, whether with eye or notch. (The notched needle tears the tissues mercilessly, and should, I am convinced, never be employed in this operation). In preference to shot, which is hard and difficult to clamp, I used gas-pipe lead, and was highly pleased with it. By cutting minute longitudinal pieces and neatly and evenly curling them up over the point of a tenaculum, the gut ends can be slipped through, and the little piece drawn up to the wound edges and easily clamped with an ordinary dressing forceps.

Let us now see what benefit accrued to the patients from both of these operations, undertaken as they were with some hope of improving the speaking voice, entailing in their performance the by no means inconsiderable manipulative trouble usually attending operations of this kind, and necessitating on the part of the patients no small amount of endurance. The following is Dr. O'Brien's report on case No. 2., in answer to queries addressed to him: "Union after operation obtained for about lower half. I applied for about a month a heated wire to aperture left near hard palate, with but partial success. Saw the patient twelve months ago; voice and distinctness in pronunciation improved, but the more obvious benefit of the operation was that no drinks returned, *per nares* as heretofore. Tension of parts considerable; muscular power and sensibility slight."

As regards my first patient, whom I again saw after a five years' interval, I am bound to say that, notwithstanding the successful operative procedure, the result in her case was sufficiently disappointing. Her pronunciation had still very much of the nasal character. There was, I believed, no improvement—certainly none was perceived by the patient, though she assured me that she

faithfully carried out my instructions. No fluids came through the nose as heretofore, but she took little notice of this, and refused to give me the least credit for the operation because it did not improve her voice. On examination I found the parts still perfectly united (a bifid uvula excepted). The tissues were, however, unduly tense, but could bear considerable stretching, and from the very trivial muscular response by local excitation, and the greatly diminished sensibility of the part, I concluded that the muscular and probably nervous apparatus had undergone partial atrophy.

Observations.—In one particular both operations resulted satisfactorily, namely in preventing fluids from regurgitating through the nostrils. This, however, particularly in the case of females, is of minor importance compared with the great aim and object of the operation, viz., the removal of the very objectionable nasal intonation in speaking. I shall, therefore, deal solely with the question of pronunciation. The first point that forcibly occurs to me as a rather curious fact, is that though union in case No. 2 was imperfect, yet some palpable improvement in pronunciation was evident (*Vide* Dr. O'Brien's report), while perfect union in the other case produced not the smallest satisfactory result in this respect. It was evidently accounted for by the performance of the operation at a much earlier age than in case No. 2. The longer the duration of a habit, the more difficult to overcome it. If this be true of an acquired habit, it is eminently so of a habit arising from a congenital physical defect. It becomes, by the growth of years, so to speak, part and parcel of one's nature, and the difficulty in overcoming it is well-nigh insurmountable. Case No. 1 was certainly a typical example of the unsatisfactory result, as far as improvement in the voice is concerned, of operating for this congenital defect in adults. Now, directing our attention solely to the first case operated on, two questions would suggest themselves.

1. To what cause or combined causes, in that particular instance, was due the failure of the operation in improving the speaking voice?

2. Given these causes, would it be within the power of the surgeon, in similar cases, to obviate or remove them?

As regards the first query, no doubt want of success was due to (a) the age of the patient and the consequent difficulty in shaking off a habit that had become more fixed as years advanced; (b) to the tension of the parts; (c) to the semi-atrophied, semi-paralysed local condition, the result of such tension, and (d) to the absence of method in the subsequent training of the pronunciatory powers. The consideration of these

combined causes of failure brings naturally to my mind certain suggestions, which, though mere after-thoughts, may nevertheless be of value.

(1) In the first place I should be very chary in future in undertaking this operation in an adult, and if tempted to do so, I should still more forcibly impress on the patient the doubtful result of the operation, and above all, I should give more explicit directions as to the subsequent training of the voice. (2) The question of tension should not be lost sight of. It is difficult, however, to see how it can be prevented. When the edges of the palate halves, so widely separated since birth, are pared and brought together, the strain, notwithstanding paralysed muscles, &c., is considerable, and becomes more so from subsequent cicatricial contraction. The effect of such strain is (a) to more or less obliterate the concavity of the soft palate, causing it to recede from the posterior nasal openings; (b) to shorten its depth between the uvula and margin of hard palate; (c) to considerably impair its sensibility and muscular power, by mechanical interference with the nutrition and function of the part, so that the velum, instead of being arched, curtain-like, loose, pliable, sensitive and muscular, is strained across in a cord-like manner and can hardly subserve a useful purpose.

In considering the means by which such a state of things may be rectified, I am forced to the conviction that had I thought of adopting such means in time, my patient would have derived benefit therefrom. I now believe that in such cases the parts should be gradually and carefully stretched subsequent to the operation, thereby giving the tissues that looseness and pliability which they ought to possess, and affording the muscles—particularly the *levator palati*—more freedom of action. The relief of tension thus afforded, would, I conceive, be also an important factor in the prevention of that muscular atrophy which must be the certain result of continued strain, as well exemplified in the case under consideration. This stretching of the parts ought to be as easily and effectually carried out here as in other situations. Performed day after day with care, and not undertaken until firm union be obtained, there should be no fear of such an occurrence as tearing the parts asunder. Of course, the surgeon should remember that the parts to be stretched are sound tissues, not cicatrices. Though my patient's case was hardly a fair criterion, considering the five years' interval that elapsed since the operation, I found that the tissues would bear a great amount of stretching, and though, at this advanced period, not hopeful of much beneficial result, still I directed her to pass her finger backwards frequently against

the part, to put it on the strain, opening the mouth well each time—a widely open mouth tending to approximate the soft parts to the posterior nares. This she could do without exciting vomiting, on account of diminished local sensibility. Unfortunately I have had no opportunity of seeing the result; the patient has since died. Selecting the proper period after the operation, I should prefer to undertake the stretching process myself, previously moderating local sensibility, if required, with cocaine. No doubt, also, this digital manipulation, regarded as a species of massage, would aid in muscular nutrition and development. Other measures that ought not to be lost sight of are yawning, swallowing, local irritation (tickling the throat if it can be borne), and, in bad cases, electricity. Above all, these measures should go hand in hand with methodical, well directed training of the pronuciatory powers. But here is surely a vexed question. Given a sufficiently pliable soft palate after operation, with its muscles in good tone, how are we to ensure the correct adaptation thereof to the wants of speech? How is the habit of mal-pronunciation to be removed, more especially if that habit, after many years' growth, be already fastened and engraven in the patient's nature? It is, at all events, plain that in the effort to remove it, the first essential item to be secured is the patient's hearty co-operation and determination to persevere for a sufficiently

long time in the slow process of training. But in what manner? Will it suffice to read aloud, or like Demosthenes, to repeat phrases to the sea waves? No; it is not a question of correct accentuating or emphasising, of raising or modulating the voice to suit certain phraseology; it is a question only of giving certain letters their due sounds, the accomplishing of which reduces itself into simply being able, while pronouncing these letters, to shut off, wholly or partially as the case may be, the nasal tube by means of the soft palate. *This the patient can practise quite as well in a whisper as in a loud voice.* And now, as regards details in such practice, I confess it is difficult to arrive at any feasible plan, and reference to special works on the voice has not given me the help I needed in this matter. It is plain, at all events, that, in the process of training, a clear knowledge of the letters and words badly pronounced is of first importance. Presuming that the local muscular condition is such as to allow of its correct, or fairly correct adaptation, by practice, to the requirements of speech, then the constant and persevering attempt to imitate the correct sounds of these badly pronounced letters or words, ought, in the end, to secure a liberal measure of success. To facilitate matters, I have taken the trouble to tabulate my ideas crudely as follows, leaving the matter for further development in the hands of specialists:—

PRONUNCIATION AS AFFECTED BY CLEFT PALATE.

		GROUP I.	
Pronounced fairly well.	M	} Requiring an <i>open nasal tube</i> , their pronunciation is practically unaffected by cleft palate.	
	N		
	L	...	...
	R	...	...
	V	...	...
	H	...	...
	Z	...	...
Vowels including W and Y		} Requiring a <i>partially open nasal tube</i> , their pronunciation is little affected by cleft palate.	
		GROUP II.	
Badly pronounced	C soft	} Mal-pronounced similarly to S. and J. (See below).	
	G soft		
	B	pronounced like Mb.	Example, Bear pronounced Mbear
	P	"	" Mb.
	F	"	" Vair
	D	"	" Nh.
	T	"	" Nh.
	S	"	" Z.
	J	"	" Zh.
	G hard	"	" H.
	K or C hard	"	" H.
	Q	"	" Wh.
	X final	"	" Hs.

Requiring a *closed nasal tube*, their pronunciation in cleft palate is therefore very defective.

With supplementary blowing nasal sound throughout.

A glance at the above will show that only a small list of words needs to be remembered. I believe the monosyllabic words which I have given in the second group (bear, pearl, fair, dear, towel, sail, judge, gun, kill, quail, ox), embrace all the defective sounds, as they require, during their

pronunciation, a closed nasal tube. If the patient can, after a long series of attempts, ultimately master their pronunciation, then complete success will have already been attained, the necessarily improved *timbre* of the voice aiding in the more pleasing pronunciation of syllabic

sounds into which enter letters of the first group. To aid in this happy result, an intelligent and sympathetic companion should be chosen, whose methodically slow, distinct, and correct pronunciation of the above, or a similar series of words, the patient should strive to copy.

It goes without saying that if no benefit be derived from the operation, it had better be left undone. It is not a mere question of uniting the cleft edges, it is "what good shall result from such union?" The surgeon may exercise exceptional manipulative skill, but the patient will judge by results only, and if the result be unsatisfactory, the surgeon's reputation will surely suffer. To arrive at success in anything it is well to study the causes of failure. I confess (and I daresay it is so with most surgeons), that I never yet did an operation or treated a patient without feeling when all was over, that such and such might have been done or left undone with advantage. I maintain that these after-thoughts with the surgeon are useful to lay hold of. In the present report I have, in my own case, tried to record them faithfully. It appears to me that reports of this nature derive value, not alone from a detailed account of operation and subsequent treatment, but also, in a special manner, from an accurate statement of what would appear as omissions on the part of the surgeon, with deductions therefrom as to his mode of treatment in future.

207 Elizabeth Street, Hyde Park,
Sydney, July, 1888.

NOTES ON THE TREATMENT OF MIGRAINE.

READ BEFORE THE MEDICAL SECTION OF THE
ROYAL SOCIETY OF N. S. WALES.

By R. L. FAITHFULL, M.D., L.R.C.P.

HEMICRANIA or Migraine consists of spontaneous paroxysmal attacks of pain in the head, separated by intervals of shorter or longer duration, which are usually free from symptoms. The pain usually affects one side of the head more than the other, is accompanied more or less by oculo-pupillary, circulatory, and calorific disturbances, with nausea and vomiting, and excited by certain reflex disturbances.

Pathology.—There is considerable diversity of opinion regarding the nature of Migraine. At one time it was regarded as being due to gastric or hepatic disturbances. Some pathologists hold it to be a form of neuralgia. Others refer it to the sympathetic nervous system. And others,

again, maintain that the phenomena are those of "a nerve storm" traversing more or less of the sensory tract from the optic thalami to the ganglia of the vagus, or else radiating in the same tract from a focus in the neighbourhood of the quadrigeminal bodies.

The following symptoms and development have been noted in the cases under consideration:—

The headache commenced early in life; the neuropathic constitution has been more or less distinctly inherited; the attacks have been paroxysmal; have come on at irregular intervals; have been usually preceded by a general feeling of "malaise" or of chilliness, with cold flashes passing through the body, and bright flashes of light before the eyes, or black spots floating about; some have complained of an indescribable feeling of "fidgets," with or without muscular soreness.

In most of the cases the pain in the head was "unilateral" (and most frequently on the left side) of a boring, throbbing, or bursting nature, usually commencing on awakening in the morning and gradually increasing in intensity. In some cases the pain would be referred to whole side of the head; in others, to the eye or over the temple; and, again, in others, in the back or on the top of the head. As a rule, light and noise could not be borne. In some, during an attack, the face was pale, the pupil dilated, and the temporal artery could be seen plainly pulsating. In others the very reverse was noted. In nearly all the cases vomiting occurred at some period of the attack, and in a certain proportion of cases would bring relief, followed by sleep. In others, the occurrence of retching seemed only to intensify the head symptoms.

June 9, 1887.—Mrs. H., aged 29, married.—Has always suffered from headaches which would last from three to eight hours, during which time she had to go to bed or lie down; after a longer or shorter period, retching would come on; she would then sleep, and usually upon waking would find herself free from the headache. About two years ago, these attacks became more frequent, and as she was a nervous lady and did not sleep well they were put down to this cause. At the present time, the least exertion or excitement of any kind will bring on an attack which will last about 8 hours. To use her own words, she says "she dreads doing the slightest thing as it is sure to end in a headache." During an attack all the secretions and excretions are stopped. At the end, retching comes on, which at times is perfectly dry; at others, a large quantity of bilious looking matter is ejected, and about the same time she passes a large quantity of water, after which she goes to sleep and wakes up generally free from headache. The pain is located in the right side of her face

and more especially in her right eye. During an attack she complains of an inability to get warm.

September 19, 1887.—Mrs. F., aged 30, married.—Has suffered from severe attacks of sick headache for 24 years. Nothing except morphine and chloral hydrate has given her any relief, and now these appear to be of little benefit. Attacks come on regularly every three or four weeks. Eggs always bring on an attack within half an hour. Over fatigue is likely to produce an attack, but a glass of brandy and water will then usually ward off the attack for some hours. Ordinarily an attack commences about 2 or 3 a.m., with a feeling of cold shivers, and this is usually more or less pronounced during the time the attack lasts, which is generally 48 hours. Retching sets in early and lasts 12 to 24 hours, and does not give the slightest relief. Pain is referred to the left side of the head and is most severe in the left eye. After an attack she has to remain in bed for two or three days longer, as she feels so prostrated and dreads the recurrence of another.

Treatment.—Antipyrin was given in ten (10) grain doses in aromatic water directly an attack is felt to be coming on, and the dose to be repeated in half-an-hour if necessary. Having taken the dose, the patient is directed to loosen her wearing apparel, to lie down in a quiet and darkened room (if possible), and to cover herself up warmly. Not unfrequently, under these circumstances, sleep follows with the first dose, and, upon awaking, all pain has left. But patients complained then bitterly upon waking of a dazed kind of feeling, with more or less giddiness. To obviate this I added potassii bromidi or sodii bromidi in ten (10) grain doses, and with the happiest results. Out of 30 cases treated thus, all but three obtained relief. None have been permanently cured, but the attacks can always be modified, and in many entirely warded off, and the intervals between them greatly increased. I have had equally as good results with "antifebrin" in five to eight grain doses, and with "salol" in ten (10) grain doses. The latter seems to act best in cases with a "gouty" or "rheumatic" diathesis. Lately I have been prescribing antipyrin with "potassii iodidi" in syphilitic headache, with the happiest results. Antipyrin in ten (10) grain doses, with potassii or sodii bromidi, will quickly relieve headache due to too free indulgence in alcohol. Antifebrin in a single dose of eight (8) grains, will act equally as well, but not quite so quickly.

5 Lyons Terrace, Hyde Park, Sydney,
July, 1888.

REMARKS ON THE TREATMENT OF STONE IN CHILDREN, WITH NOTES OF A CASE OF LITHOLAPAXY.

READ BEFORE THE MEDICAL SOCIETY OF QUEENSLAND, ON JULY 10, 1888,

BY WILTON LOVE, M.B., VISITING SURGEON TO THE BRISBANE HOSPITAL FOR SICK CHILDREN.

THE subject of the operative treatment of stone in the bladder has been brought so prominently before the profession of late, owing to the revival of the old high operation, that every case now possesses an added interest and becomes worthy of record, for it is mainly from a mass of statistics that we can formulate definite results, and indications as to which operation should be selected. Statistics, I know, are capable of endless manipulation, and can be made to prove almost anything or nothing if taken alone, but where a judiciously conceived operation is backed by a large and truthfully recorded measure of success, it is at least the duty of a surgeon to give that operation due consideration and weight, in spite of his own personal prejudices—prejudices which often owe their origin to traditions, opportunities, or personal success.

The treatment of stone in children has always met with brilliant success; more so than any other of the major operations, and it has been repeatedly urged that the splendid results of lateral lithotomy do away with the need for any other form of operation. But, if the small mortality of the lateral operation can be reduced to a still smaller one by any other proceeding which does not show greater disadvantages, then by all means let us select that proceeding.

Let us glance for a moment at the figures of the three great operations for stone in children, viz., the lateral and supra-pubic cystotomies, and the crushing operation. I have collected from *The Lancet*, *British Medical Journal*, *Edinburgh New Journal*, *London Medical Record*, and *Australasian Medical Gazette*, for the last three years, the following cases:—

1. *Lateral Lithotomy.*—Coulson's report, quoted in *Erichsen's Surgery*, vol. ii, p. 272, shows that the mortality under 10 is 1 in 13, or 7.6 per cent., and under 20, 1 in 11, or 9 per cent. From the sources quoted above, I have collected the following results of Cheselden's operation in children during the past three years. The surgeons referred to include MacCormack, Keelan, Freyer, Thompson, Kovacs, Marshall and Owen.

There were 526 cases recorded, with 15 deaths, a mortality of 1 in 35, or 2.8 per cent., a result much better than that given in Coulson's table.

2. *Supra-pubic Lithotomy*, as reintroduced by Petersen and Schmitz, and practised on children during the last three years, gives us 56 cases by the following surgeons:—Barham, Pitts, Greenwood, MacCormac, Golding, Bird, Page, Walsham, Kovacs, Marshall, Bond, Gibson, and Hardie. These 56 cases show 8 deaths or 1 in 18·6, a mortality of 5·3 per cent.

3. *Litholapaxy*, as practised by Keegan, Freyer and Walsham, gives us 188 cases from the following surgeons:—Keegan, Walsham, Uthoff, Clutton, Pye, Thompson, Kovacs, Marshall, and Freyer. In these 188 cases there were 4 deaths, or 1 in 47, a mortality of 2·1 per cent.

To recapitulate:—

Operation.	Cases.	Deaths.	Mortality.
Lateral Lithotomy	526	15	2·8 per cent.
Supra-pubic Lithotomy	56	8	5·3 per cent.
Litholapaxy	188	4	2·1 per cent.

In an admirable paper by Mr. Walsham in the *British Medical Journal* for October 15, 1887, he summarises the chief points in favour of litholapaxy in children thus:—

1. The absence of the risks attending a cutting operation.

2. The absence of all after-annoyance from the urine escaping through the supra-pubic wound should union not occur.

3. The rapidity of the cure—the patient being, in the great majority of cases, convalescent the day after the operation.

4. That it possesses, in common with the high operation, the advantage that the genito-urinary organs remain intact, and the danger of emasculation in consequence of interfering with the ejaculatory ducts is avoided.

(In connection with this point, which is still quite undecided, I would suggest that every surgeon who is able to trace the after history of any boy or man who has been cut by Cheselden's method should do so and record the result. It is a point of the greatest importance and should, I think, be made the subject of enquiry by the Special Investigation Committee of the British Medical Association in England. Schmitz records 18 cases, of which 12 had no issue. I have come across two cases; one has never had issue, although married 10 years, and the other, who was cut at the age of 31, has had no issue since,

though there were three children before the operation.)

The objections raised to lithotripsy in children are—

1. The undeveloped condition of the genito-urinary organs.

2. The smallness of the bladder.

3. The narrowness of the urethra and its extreme sensitiveness and liability to laceration.

But, as Walsham truly says, experience will shew these to be chimerical. In my own case, a small boy, aged two years, the urethra, after the meatus was incised, admitted a No. 7 lithotrite and a No. 8 evacuating catheter with comparative ease, and no difficulty was experienced in seizing the stone or crushing it, although the lithotrite was an old-fashioned instrument.

The calibre of the urethra does not bear any direct relation to the size of the child, and in most cases it will be found to admit an instrument quite strong enough to dispose of the stone.

The meatus must be incised before the surgeon can say that the urethra will not admit a given instrument. Greater delicacy and gentleness are, of course, necessary than in the operation on the adult, and often greater patience, as the small size of the catheter does not admit of rapid evacuation till complete trituration has taken place.

With regard to the choice of a lithotrite, Keegan recommends a short-beaked instrument with the female blade completely fenestrated, and with the Bigelow handle and lock.

I will now content myself with reading the notes of a case upon which I had recently the opportunity of testing the operation.

Fred. Raven, aged 2; admitted into the Hospital for Sick Children on May 18, complaining of much pain in passing water. The symptoms had existed for six months. Three months ago he was circumcised by a medical man in South Brisbane, who put the symptoms down to a long prepuce. On examination a small stone was detected behind the prostate, and with the finger in the rectum could be made out to be about the size of a hazel-nut, but flatter. On May 31st, with Dr. Hill to give chloroform, I crushed, using No. 7 lithotrite and No. 8 catheter. The meatus required to be incised, but this done the urethra admitted the instruments named comfortably. The stone measured $\frac{1}{2}$ in. one way and $\frac{3}{4}$ in. across. The lithotrite was introduced three times and the catheter twice, when the operation had to be stopped owing to the alarming state of syncope into which the child had fallen. It was half-an-hour before he breathed comfortably, when he was put to bed with hot bottles round him and a fomentation on the bladder. He cried a little during the night on making water, and passed

some debris. Urine clear, no blood. Next day he appeared quite well, but crying a little on micturition. Temperature normal, urine clear. At the end of a week, as he still cried occasionally, he was again examined, and another fragment found, which was crushed. The same syncope came on as before, though ether was used on this occasion, and the evacuation of a few of the last fragments had to be left to nature. He passed a little debris that night, and since then he has had no pain or trouble of any kind, and the day after the second crushing he was practically well. There had been no rise of temperature, no swelling of the penis, and no blood in the urine after either operation. The stone was a uric acid one, and the fragments when dried weighed 18 grains, which with what was passed probably brings the weight up to about 80 grains.

AN UNUSUALLY RARE CASE OF PLURAL BIRTHS.

By PARK P. BRENNEMAN, M.D.

On June 20, 1888, I was called in to attend Mrs. Rattenbury, residing at Tempe, near Sydney, who had the previous day given birth to quadruplets. She was suffering with severe after pains and very painful hæmorrhoids.

From the patient and midwife I have succeeded in getting a very good history of the case, which I think will be interesting to the profession on account of its rarity, as I think it only occurs on an average of once in ten thousand cases.

The patient I have frequently had under my care suffering generally from cardiac asthma, consequent on an attack of rheumatic fever; she never enjoys good health. Her family history shows no tendency to plural births. She is thirty-one years of age, was born in Tasmania, first menstruated between seventeen and eighteen, was married at the age of eighteen, since which time she has given birth to seven full-time children, the youngest of which is two years and eight months old. Her previous labors have been rather unnatural; says she has had three cross-births and had to have the children turned.

Her last menstruation was from December 20th to New Year's Day, quickened the middle of April; says she did not have a day's good health while carrying, no appetite, and was an immense size, in fact a burden to herself near the last, feet and legs very cedematous, and noticed very little movement with the exception of an occasional flutter.

She was first taken ill on the previous Friday and had an occasional pain until Tuesday about 11 o'clock, when the membranes containing the first child ruptured and there was an immense gush of liquor amnii; her husband just happened to come into the house, and noticing the condition of affairs assisted her into bed, when she immediately had another pain and the first child was expelled. He ran for the midwife who was there five minutes afterwards. She had scarcely time to tie the cord and remove the child when another pain ruptured the membranes containing the second child, and there was a second gush of liquor amnii; another pain expelled the second child, which was followed by the placenta, with the two cords attached. But a few minutes elapsed when another pain ruptured the membranes containing the third child, when there was another gush of liquor amnii, which was followed by the third child with its placenta.

The midwife thinking she had come to the end of the string made preparations for applying the binder, when the membranes containing the fourth child ruptured, when there was another gush of liquor amnii, and with a few pains the fourth child was expelled with its placenta. There was very little hæmorrhage. The labor was quite natural. The children were expelled head first, with the exception of the fourth, which was expelled feet first. The labor was very short, there being but thirty minutes from the time the first child was born to the completion of the labor; ten minutes between each child. The children were all born alive, and lived from two to six hours and a half.

I examined the children and found them to be as large as the usual 5½ month child, perfectly formed and exceedingly well nourished; three girls and a boy. The mother made an uninterrupted recovery, and was out of bed on the eleventh day.

228, Macquarie Street, Sydney.

[NOTE.—This case, though sufficiently remarkable, and one likely to strike terror into the hearts of nervous married men as to the possible risks they have undertaken when venturing on matrimony, does not entitle Australia to claim the first position as the home of the mother having exhibited the greatest effort to increase the population of her country during 1888, for a lady, the wife of the local magistrate at Castagnola, in Switzerland, was delivered on May 4th, by Dr. Vassoli, of six children, at about the fifth month of pregnancy, the mother making a good recovery. —Ed. A.M.G.]

NOTES ON A CASE OF IVORY EXOSTOSIS OF THE EXTERNAL AUDITORY CANAL, TREATED BY DRILLING WITH THE DENTAL ENGINE.

By A. J. BRADY, L.K.Q.C.P. IREL., L.R.C.S.I.,
HON. SURGEON TO THE EAR, NOSE AND THROAT
DEPARTMENT, SYDNEY HOSPITAL.

B., AGED 45 years, came to the Out-Patient Department at the Sydney Hospital on August the 12th, 1887. He was so deaf in the right ear that he could not distinguish words shouted loudly close up to the auricle. He was also dull of hearing on the left side, which proved on examination to be caused by old adhesions in the middle ear, the result of chronic inflammation. The right ear, till latterly, had always been the better one, when it became gradually deaf.

On examining the right ear, instead of seeing the membrane tympani, the auditory canal was seen to end in a cul de sac.

An exostosis, covered by the normal integuments of the parts, sprang from the floor and posterior wall of the canal, filling it completely, so that only a slit-like depression in the integuments showed where the growth infringed on the superior wall. Through this slit even the finest probe could not be introduced. The exostosis was very deep in the canal. By measuring the distance from the external meatus to the growth, and comparing it with that of the other ear, I concluded that the growth must be pressing against the membrane tympani. The difference in the depth measuring on the right side, from the membrane tympani, and on the left from the exostosis, was only about a line and a half.

The patient was taken into hospital, and although, it is well known that the removal of an ivory exostosis, so deeply seated as this, is not unattended with danger, still I felt that to leave the patient alone would expose him to a still greater risk, as he had some tenderness about the ear, and his temperature rose to 101°, showing probability of retention of secretion behind the exostosis, and the possibility of cerebral abscess supervening if vent were not given to the pent up secretion. I also expected to improve his hearing. With the tuning fork, I ascertained that sound perception by bone conduction was good. Having determined that it was advisable to remove the exostosis, I selected the dental engine as the best means of doing so.

Mr. G. P. Field, of London, was the first to bring this method prominently before the profession in England, (*British Med. Jour.*, Feb. 27th, 1886, April 30th, 1887). In his earlier

operations he used a spoon-like steel guard, which he got behind the growth, to prevent the drill injuring the middle ear in case of slipping. Latterly he uses for the same purpose a cross bar at the end of the drill holder, which allows the drill to go only a definite depth in the canal.

In my case neither expedient could be used, for as the whole lumen of the canal was closed by the exostosis, it was not possible to introduce a guard behind it, and as the growth was so deeply seated, the cross bar, to be of any use as a guard, would have to be actually pressing against the soft parts of the ear in order to allow the drill to reach the growth, thus preventing the view of the parts which is necessary.

The patient was put under ether, and the electric light reflected from a forehead mirror used to illuminate the auditory canal. No speculum was used, but I drew the auricle back with my left hand, and an assistant held the tragus forward with a retractor.

I applied the drill at the slit-like depression at the upper limits of the growth and worked away cautiously, withdrawing the instrument frequently to remove the blood by syringing and swabbing. Notwithstanding frequent drying up of blood, I found it difficult to keep a good view of the parts; so as soon as I judged by probing that I had got through the exostosis, I determined not to do any more that day, but to widen out the opening on another occasion. The growth proved to be very dense. No reaction followed this operation, the patient felt relieved of the pain in the head, and the temperature fell to normal in a day or two. The ear was daily syringed, dried, and filled with boracic acid in fine powder. The second operation, undertaken eight days afterwards, consisted in widening the tunnel through the growth with a larger drill. No pain or fever followed. The ear was daily dressed as before for several weeks. For some time there was not much improvement in the hearing; this one would expect as the opening was constantly filled with discharge. He afterwards became an out-patient; the discharge gradually ceased, and one day when I cleaned out the tunnel, made by the drill, he found all at once that he could hear distinctly. He went up country, and although he was camping out in rather cold weather, the ear gave him no trouble. About a month later I examined him and found the ear quite healed and the little tunnel lined with the normal integuments of the ear. He hears conversation at the distance of eight paces.

I am indebted to Mr. Hodgson, Hon. Dentist to the Hospital, for assisting me in the use of his dental engine at both operations.

3 Lyons Terrace, Hyde Park, Sydney.

TEN SUPRA-PUBIC OPERATIONS.

READ BEFORE THE S. A. BRANCH, B.M.A.,

BY WM. GARDNER, M.D., HON. SURGEON ADELAIDE HOSPITAL, AND LECTURER ON SURGERY,
UNIVERSITY OF ADELAIDE.

No.		Name.	Sex.	Age.	Date.	Operation.	Anæsthetic.	Result.	Remarks.
1	H.	T. E.	M.		22/7/86	{ Lateral and Supra-pubic }	Ether.	Cured.	{ Mulberry Calculus removed, weight gr. 2,900.
2	H.		M.		10/12/86	Supra-pubic	"	"	Oxalate of Lime Calculus.
3	H.	S.	M.	65	27/7/87	"	"	"	Uric Acid Calculus.
4	P.	T.	M.		20/9/87	"	"	"	" " "
5	P.	G.	M.		20/9/87	"	"	"	To drain a dilated bladder.
6	P.	C.	M.	65	6/11/87	"	"	"	{ Uric Acid Calculus removed, weight gr. 288.
7	H.	S.	M.	65	2/4/88	"	"	"	{ Second operation—Phosphatic Calculus removed.
8	P.	E.	M.		15/4/88	"	"	"	Chronic Cystitis.
9	H.	B.	M.		18/4/88	"	"	"	{ Drainage for the cure of Per- ineal Fistulæ.
10	P.	B.	M.		2/10/87	"	{ Chloro- form. }	"	{ Five or six malignant Tumours of the Bladder removed.

Remarks.—I have operated ten times upon the bladder by the supra-pubic method, being driven to use it in my first case by the large size of the stone (which was an oxalate of lime calculus, weighing over 38), after it was evident that it could not safely be removed by the perineal route. All the patients recovered from the operation, but No. 1 died three months afterwards from epithelioma, involving the sites of both supra-pubic and perineal wounds, and reopening them. Four others were operated on for stone by this method and all recovered, one of them (case No. 3) being operated upon a second time by the same method, a uric acid calculus being removed the first time and a phosphatic one at the second. As the patient was 65 years of age, and the urine was persistently alkaline, I have kept a vulcanite canula in the bladder as a permanent drain, and I do not think that he will ever be able to leave it out. He is, however, fairly comfortable, and were it not for the fact that his sight is bad, he might easily wear a stopper in the vulcanite canula and remove it when he wanted to pass water. As his sight does not permit him to do this, I have fastened a rubber tube on to the end of the canula and directed it into a urinal fastened to the thigh.

No 10 was operated on in Melbourne for tumours of the bladder, and they were removed as completely as possible by Sir Henry Thompson's forceps; but the patient died three months afterwards, and Dr. Springthorpe, who examined the growths, reported them to be malignant.

Three cases were operated on for chronic cystitis, to effect drainage and washing out of the bladder; but I have come to the conclusion that Sir Henry Thompson's operation by the perineal opening is better, as, when the urine is abnormal, the supra opening is long in closing, and causes much more trouble, because the urine flows all over the lower part of the abdomen.

With regard to the operation, I consider that it is the easiest of all the operations for stone in the bladder, and that both rectum and bladder should be distended (except in cases where the bladder is very much diseased, as in case No. 7, where the rectum only was distended). For the rectal distension I use a large size Barnes' uterine bag, and the bladder is distended by about 38 of boric acid lotion. The catheter is then withdrawn and a rubber ring wound round the root of the penis, or the catheter may be left in with the end plugged, and the handle may be depressed and the bladder opened on the point. In cases of stone, Professor Annandale's method might be used, by grasping the stone in the lithotrite, and then depressing the handle before opening the bladder, the lithotrite then presenting the stone at the opening. I have devised scoops for removing the stone, and Messrs. Mayer & Meltzer, of Melbourne, have very carefully carried out my ideas. (Scoops shown).

The only special point I can see in the operation is that the dissection down the bladder should be continued in straight lines, and that there should be no lateral separation of the tissues.

With the exception of case No. 1, which from the exceptional size of the stone required suturing of the bladder, I have not used any sutures. In no case was there any sign of peritonitis, and in only one case was the peritoneum seen during the operation, and then it was easily drawn out of harm's way.

ERYTHEMA NODOSUM, ACCOMPANIED BY UNUSUAL EYE SYMPTOMS.

READ BEFORE THE S. A. BRANCH, B.M.A.

BY LEONARD W. BICKLE, L.R.C.P. LOND.,
M.R.C.S. ENG., OF MOUNT BARKER, SOUTH
AUSTRALIA.

ERYTHEMA Nodosum is a disease that is generally dismissed in a few lines in our text-books, although it is an affection that cannot be described as uninteresting; possibly, too, it is treated so because it never proves fatal.* Curiously, too, it has never procured for itself any popular name. We have urticaria, with its synonyms of nettle-rash and hives; eczema, as moist tetter, baker's itch, &c.; scabies, as the itch, &c., &c.; but when asked by our patient or her friends as to what the disease is called, one can only say it has no common name, but that technically it is known as *E. nod.*; possibly this is no real disadvantage, for many patients are the better pleased to have an ailment with a long name, and seem to derive some consolation in their trouble from such a fact.

Although classed with the skin diseases, and with the mildest of them, I believe it is wrongly classified. Its duration, constitutional disturbance, and the painful character of the nodes, seem to leave it nothing in common with the usually mild characteristics of the erythemata. But it is not my object to discuss this question to-night, but merely to relate the particulars of the cases that have come under my care during my residence in South Australia, as several of them present features of interest.

Soon after my arrival in this colony, when practising at Gawler, I happened to have four cases of *E. nodosum* under treatment about the same time, the various patients, however, living far apart. In each of these cases I had the same eye affections. Not having noticed this feature

in the old country, I wrote to the late Dr. Charles Gosse, thinking it might be a common complication out here; he wrote me that he had neither noticed nor heard of the combination, but agreed with me that the affection was phlyctenular conjunctivitis, but said that the possibility of its being herpetic had occurred to him (this latter remark had special reference to Case II).

Later on in the same year (1884) two other cases came under notice, in one of these the same eye trouble arose, in the other the eyes remained unaffected.

Since settling in Mount Barker, I have had three other cases. In the first of these the eyes were not involved. In the other two cases (both this year) the eye symptoms cropped up. The occurrence of the same eye symptoms in seven out of nine cases, points to more than a mere coincidence, and leads me to bring the subject before the society; for even if of no great importance, the symptom is an interesting one, and may help to throw light on a disease which is not yet thoroughly understood. I have not been able to find any mention of the symptom in the books at my command, and Dr. Symons, who has very kindly looked up the subject for me, says he can find no mention of it. The only remark bearing on it he quotes from Meyer, of Paris, who says—"The concurrent appearance, either before or after its commencement, of cutaneous eruptions of the eyelids or of the surrounding skin, such as eczema or zona, seems to point to phlyctenular conjunctivitis as an exanthematous disease of the mucous membrane depending on the ciliary nerves."

I also find that Nettleship quotes Dr. Barlow as having met with photophobia and congestion of the eyes in acute rheumatism, but no mention is made of there being either phlyctenules or *E. nodes* as well.

Case I.—An anæmic girl about 16 years old. At first nature of complaint not clear, a slight febrile temp. (101° to 102°), diarrhoea, and a few rhonchi over chest, making one suspect enteric fever, which was then very prevalent. On the third and fourth day there were pains in knees and shoulders, and the nodes soon appeared on both legs below the knees, on the left thigh, and one on left forearm. When the rash was well out attention was drawn to the eyes. There was a gelatinous swelling rather larger than a pin's head on either side of the cornea in both eyes, with numerous injected vessels, no pain and only slight photophobia. Calomel was dusted in and the eyes were well in about a week. The *E. nod.* were treated locally with *lot. plumbi*; internally by *sod. salicyl. c. tinct. cinchonæ* co.

* Dr. A. Van Harlingen, Professor of Diseases of the Skin in the Philadelphia Polyclinic, reports a case in which a little boy, after suffering for three or four weeks with erythema nodosum, fell into a delirious condition and died, with the symptoms of tubercular meningitis.—*Ed. A.M.G.*

Case II.—A married woman, about 28 years, somewhat anæmic. When first seen, suffering from diarrhoea, temperature 101° to 102° , and on both sides of neck a copious eruption like an abortive herpes; this rash was very painful, and on the right side extended on to the face, taking the distribution of the crow's foot. Wrists and knees were painful. The erythema nodes appeared, but the temperature went up to 103.5° , and several of the joints became swollen and acutely tender, and there was copious sour perspiration. The eyes were affected in the same way as in Case I., as there was no pain they were treated expectantly, and were well in about ten days.

Case III.—An anæmic girl of about 10 years. This patient was brought to the surgery complaining of pains in knees and shoulders, well marked nodes were found on the legs. Not seen again, but the mother came in a few days later exclaiming in voluble Irish fashion about the dreadful disease coming out in the eyes "entirely," leaving no doubt but that the same condition was present. About 10 days later the eyes were reported well.

Case IV.—An anæmic girl of 16 years. Pains in knees and ankles, not seen for four days, when eyes presented the appearance described in Case I. They were well in 10 days without treatment.

Case V.—An anæmic girl of 18, but well developed. Well marked erythema nodes; about the fifth day the right eye presented a typical phlyctenule. A curious feature in this case was a persistent frontal headache, which, for a time, defied all treatment. Quinine, iron, bromides, chloral, guarana, purgatives and stomachics were all tried without effect. Dr. Ringer states that in some cases of frontal headache, due to rheumatic diathesis, iodide of potassium is often useful, so I put patient on pot. iod., gr. x. every four hours, with immediate and permanent relief. This result is specially interesting in the light of the connection between this disease and rheumatism.

Case VI.—Well developed girl, aged 19. Not anæmic. Nodes on both legs below knees. Considerable œdema of both feet, and ankles. No albumen in urine, and heart sounds clear. In this case the eyes were not affected.

Case VII.—An anæmic boy about 10 years. An immense number of nodes on legs, thighs, and both arms. Have no note of eyes being affected in this case. The disease not yielding rapidly to the sod. sal. c. t. cinch. co., I put him on full doses of t. ferri perchlor. with great benefit.

Case VIII.—An elderly woman, between 55 and 60 years of age, not anæmic. When first seen, slightly feverish, complaining of pains in

limbs and back, slight bronchitis. A few days later showed me her two thumbs which had red swollen patches, painful and itching very much; next day ulnar sides of both palms and little fingers affected in same way; complained of eyes being weak and watering a good deal. Typical phlyctenule, of the yellow pustular form, on nasal side of both eyes, mid-way between inner canthus and cornea now made their appearance. On seeing this I predicted that nodes would appear on the legs as well. These appeared as characteristic E. nodes on both legs, thighs and also forearms. In this case the throat was affected, follicular tonsillitis. The eyes were greatly relieved by the calomel, followed by a zinc sulphate lotion. There was both pain, photophobia, and much watering.

Case IX.—A well developed but somewhat anæmic woman of about 30. Had been suffering from sore throat. On both sides of neck an eruption like an abortive herpes and very painful; temp. 102° . Nodes on legs, and one very tender and large one over left knee, joint too tender to move. There was a good deal of effusion in joint, and subsequently both the ankles and right wrist were swollen and acutely tender. The right eye had a typical phlyctenule on nasal side, there was pain and watering. Heart not involved.

These, gentlemen, are the brief outlines of the cases of this disease which have been under my care during the last four years, and they present, I think, several points of interest.

1st. The occurrence of the eye symptoms in seven out of nine cases. In five cases both eyes were involved; in two cases one eye was affected; and in the remaining two no eye symptoms were noticed. It is worthy of remark that I had no cases of either phlyctenular or catarrhal ophthalmia at the same time.

2nd. The close relationship shown to acute rheumatism. In two cases, both married women, after the rash appeared, and whilst the nodes were still fully out, the temperature increased and several of the joints became not only tender but distinctly swollen. Trousseau says he had never seen the joints swollen, but in the last case not only was there effusion into left knee, but also in both ankles and the right wrist. Another evidence of the relationship to rheumatism is shown in the persistent frontal headache relieved by pot. iod. in large doses, and again it was noticeable that the pains were relieved by the salicylates in all cases.

3rd. Another curious point was the occurrence in two cases of an eruption on the neck, the patches closely resembling those of Herpes Zoster, but no vesicles appeared. In both cases great pain was complained of over the area covered by

the rash, and in both cases several joints were affected.

4th. The preponderance of females attacked by this disease over males is well borne out, eight out of the nine being females. In one case the menses appeared during the height of the disease, one patient was passed the climacteric.

5th. The occurrence in one case of the nodes on the hands in the first instance. In this case I contented myself with saying the affection was an erythema, but the rapid appearance of the phlyctenules in the eyes, made me confident that I had an unusual development of *E. nod.*, so that the symptom became of diagnostic value.

As regards treatment, I generally find that benefit is derived from salicylate of soda in conjunction with sodæ bicarb. and the tinctura cinchonæ co. When the febrile stage is over, and the nodes are disappearing, the tinct. ferri perchlor. or the ferri et quininæ citratis are indicated. Locally wrapping up the parts in cotton wool by itself, or over lint steeped in the lot. plumbi gives great relief.

The eye symptoms I found in some cases did not call for special treatment. If there was pain, the dusting in of calomel relieved both that and the photophobia, a lotion of zinc sulphate (2 grs. to loz.) completing the cure.

NEPHRO-LITHOTOMY BY TERRIER'S TRANS-PERITONEAL OPERATION.

READ BEFORE THE S. A. BRANCH, B.M.A.

By W. GARDNER, M.D. GLAS., HON. SURGEON, ADELAIDE HOSPITAL, AND LECTURER ON SURGERY, UNIVERSITY OF ADELAIDE.

Mrs. D., æt. about 55 years, had been several times under my care from Nov. 10, 1886, for slight attacks of dyspepsia, which, under careful dieting, with the use of hydr. acid and pepsine with the meals, were rapidly recovered from. Examination of the abdomen and of the chest revealed nothing abnormal, and the urine was also found to be normal. On March 6, 1888, another attack occurred which was not relieved by medicinal treatment, and another examination of the abdomen was made with the result of finding an enlargement of the left kidney. On March 29, I called Dr. Verco in consultation, and we concluded that there were symptoms pointing to a collection of fluid in or around the left kidney. We advised aspiration, which was carried out March 30, and 4 ounces of light amber-coloured fluid were removed, without any odor of urine.

With nitrate of silver the fluid yielded a copious white precipitate, and microscopically there were no signs of hydatid. Professor Rennie, by chemical analysis, could only find traces of urea. We were thus left in doubt whether the case was one of hydatid or hydro-nephrosis. After the operation the kidney swelling disappeared, three weeks after it enlarged again, and with the assistance of Dr. Verco (Dr. Giles administering ether), on April 18, 1888, the abdomen was opened by Langenbeck's incision, outside of the left rectus, and the parietal peritoneum was stitched to the edges of the wound. The visceral peritoneum was then divided and also stitched to the edges of the wound. The cystic swelling was then incised sufficiently to admit the forefinger, and on introducing it I could feel a small piece of calculous matter about the size of a split pea; this I removed, and on examining still further, I found a small fragment also embedded in what I had then discovered to be the renal tissue. I tried to remove it with the nail, but found that on scratching the tissue, the stone appeared to become larger, and inserting a knife along the finger I incised a calyx and removed an irregularly-shaped calculus weighing 96 grs. There had been a doubtful history of an attack of renal colic, but it was certainly on the opposite side. A glass drainage tube was inserted, and the wound dressed with gauze and salicylic wool.

The highest temperatures recorded were 99.2° on the second day, and 99.6° on the third day; on every other occasion the temperature was normal.

Urine was passed spontaneously on the day of operation, and the patient only vomited once after the ether.

April 19th.—Wound dressed; slight reddish-coloured discharge from drainage tube, which was taken out, cleansed and replaced.

April 20th.—Urine passed in last 24 hours, 10½ ounces. Bowels opened, and flatus passed freely. Carbolic gauze causing irritation of the skin, and changed for salicylic wool.

21st.—Urine passed, 14 ounces in 24 hours.

22nd.—Urine passed, 19 ounces in 24 hours.

23rd.—Urine passed, 23 ounces in 24 hours.

24th.—Urine passed, 31 ounces in 24 hours. Glass drainage tube removed and rubber tube substituted. Wound washed out daily with warm boric acid lotion.

From this date the amount of urine continued much the same.

27th.—Tube shortened.

28th.—Tube finally removed.

At this date Professor Rennie examined the urine, and reported 254½ grs. of urea in the urine, which was collected during 24 hours.

Remarks.—It is probable that all doubtful conditions of the kidney requiring surgical interference had better be attacked by the abdominal incision, and the lumbar incision reserved for those cases in which the diagnosis is either absolutely certain, or for cases in which the contained fluid, whatever it may be, points to the loin.

SUPRA-PUBIC LITHOTOMY.

READ BEFORE THE QUEENSLAND MEDICAL SOCIETY,

BY DAVID HARDIE, M.D., LATE DEMONSTRATOR OF ANATOMY, UNIVERSITY OF ABERDEEN.

THE arguments for and against the high operation of cutting for stone have been so frequently brought before the profession of late years that it would be a mere waste of time on my part to enumerate them. If any one here is specially interested in the subject I would remind him of a very instructive paper read before this Society last year by Dr. Gibson, and which appeared in the *Australasian Medical Gazette* of July, 1887.

The operation of supra-pubic lithotomy is not a new one, but on account of its high rate of mortality it was discarded as impracticable. Even now it cannot be said to have established itself; for while, according to Sir Henry Thomson, the mortality in the low operation is 1 in 8, we have Erichsen stating in his latest edition, from observations taken in nearly 400 cases, that in the high operation it is 1 in 8; and in this he is supported by Humphrey, who has collected statistics of 104 cases. It would be interesting to have an analysis of those operations alone that have been made in its improved form, for I feel confident the mortality would appear in a more favourable light.

In performing the high operation we have two main dangers to contend against, namely, that of wounding the peritoneum and so exposing the patient to the risk of peritonitis, and secondly of extravasation of urine; and it is chiefly to make a few comments on these dangers that I have ventured to introduce the subject here to-night.

With regard to the first danger, Garson was the first, in 1878, to demonstrate the effects of a rectal tampon in raising the prevesical fold of peritoneum; and it was left to Petersen, in 1880, to follow up Garson's observations and to act upon them, thereby giving us an operation now known by his name. In the case of children, Barwell, Trendelenburg, and Schmitz think it immaterial

whether rectal injection be employed or not, and state that moderate distention of the bladder alone renders the peritoneum safe. Whether they base this assertion on their practical application of the operation or on the fact merely that in children the peritoneum is relatively higher than in adults, I do not know; but when we remember that, according to Pitha, the peritoneal reflection in children under 8 years is not more than two inches below the umbilicus, we can well imagine that, without much dilatation whatever, the operation might be conducted without injuring the peritoneum at all. In the case of adults we are chiefly indebted to Fehleisen, who, in 1884, published the results of various experiments made by means of frozen sections, and by which he has conclusively proved the truth of Garson's and Petersen's experiments. He has shown that should the rectum be empty, moderate distention of the bladder, by injecting 10 ozs. of fluid, raises the prevesical fold about $\frac{1}{4}$ of an inch; and full distention of the bladder, by injecting double that quantity, raises it $\frac{3}{4}$ inch. He has also shown that should the rectum be first distended by the injection of 17 ozs. of water—even 7 ozs. of fluid in the bladder will raise the fold $1\frac{1}{2}$ inches, and double that amount of distention will raise it $3\frac{1}{2}$ inches. This proves to us the benefit of first distending the rectum, for, if empty, the distended bladder alone has no support below, and instead of rising towards the umbilicus falls backwards and upwards. If such be the case in adults, we may take it for granted that the same applies to children; and although in the latter the peritoneal fold is anatomically in a higher, and consequently safe position, still, in order to make it doubly safe, I think it at least expedient to dilate both rectum and bladder in children as well as adults, no matter how young they be.

With regard to the second danger, there can be no doubt if the wound in the bladder be left open that there is great risk of extravasation of urine; but, on the other hand, if it be closed up with the object of obtaining primary union, this risk is, I believe, infinitesimal, and why it should not be closed up I do not know. If left open for the purpose of having free drainage and allowing free escape of urine, have we not already the best natural channel of all left open, namely, the urethra? But even granted that the urine can get exit in this way, is it possible to obtain primary union in an organ which must necessarily vary in size and so cannot easily be kept perfectly at rest? If the patient be asked to pass his water voluntarily, with or without a catheter, I think it would at least be an improbable thing to obtain primary union of the bladder, for during the act of mic-

turition the muscular fibres would be put upon the stretch, and the internal pressure of water being the same in every direction, some of it would tend to ooze out through the recent wound and so prevent union. But if the water be drawn off through a catheter by means of a small syringe—and best of all a glass syringe—at short intervals of say two hours. The bladder in the first instance is never much distended with urine, and in the second the contractile power of the muscles is not brought into play, the bladder merely falling down passively as it becomes emptied of its contents, and in the same way rising as it fills again, and if this be carried out for a week or so until the wound has had time to unite firmly, I am confident there is no need for it to be left open, and as a matter of course the danger of extravasation of urine is practically nil. I confess this frequent application of the catheter may be open to some objections, but I look upon it as the least of two evils, consequently would advocate its practice, based as it is on a sound physiological principle.

Charles O'Brien, aged 13 years, of lymphatic temperament, came to my house in February last complaining of great pain at the point of the penis after micturition and of having a few hours previously passed a quantity of blood in his urine. The pain dated three years back, during which time he twice passed bloody urine. Otherwise he felt so well that till now he never even told his parents. On passing the sound a stone could easily be detected in the bladder. Three days after I made another examination, when to my astonishment a stone was now made out in the membranous portion of the urethra, about $\frac{1}{4}$ inch behind the bulb, and felt by the finger per rectum. Next day he was examined by Dr. Gibson, and the stone being still in the same place we decided to extract it by perineal section. Meantime, he passed his water without the least difficulty, and by the parents' request the operation was delayed for some time. When seen again and examined six weeks after, there was no stone in the urethra, but one could be made out by the sound in the bladder. Whether this was the same stone he previously felt in front of the prostrate gland I do not know; but I hardly think it probable and believe rather that there were originally two stones—the one having passed by the urethra, the other still remaining in the bladder.

On 10th April, 1888, he was admitted into the Sick Children's Hospital for the purpose of having the calculus removed. At first I intended crushing it, but not having a large enough evacuator, decided on doing the high operation. This was done, accordingly, on the 13th, in the presence of Drs. Jackson, Hare, Hill, and Gibson,

the two latter assisting me, and Dr. Love kindly giving chloroform. After being anaesthetized, I inserted into the rectum a small round india-rubber bag—obtainable in any toy shop, and used by children when blown up as miniature balloons—and which answered the purpose splendidly, and distended it by injecting 8 ozs. of water. I then took an elastic tubing, 2 feet in length, having at its far end a funnel-shaped, glass receiver, and fixed it by the other end to a gum-elastic catheter. This latter was introduced, the bladder washed out and then filled by slowly pouring a weak solution of carbolic acid (1 to 1,000) down the receiver until it ceased running. I may here mention that I think this method safer than that of injecting it, because the bladder is not *forced* to hold more water than it can possibly contain, and even though a larger quantity may have run into the bladder than you would care to inject, you not only get the benefit of the increased distention, but feel confident and easy in mind that the bladder is not over distended. In this way 7 ozs. slowly ran down the tube—a quantity which probably we would not have exceeded had the syringe been used—but afterwards this was increased to $11\frac{1}{2}$ ozs. The catheter was left in and the tube tied with tape to prevent the water running out again. The bladder was now prominent, and rose to within $1\frac{1}{2}$ inch of the umbilicus. Standing on the left side of the patient an incision was made over the linea alba, beginning at the symphysis pubis, and extending $2\frac{1}{2}$ inches upwards—the various tissues cut through with a knife, or separated by the handle of a scalpel directly in the middle line, and the bladder was reached without exposing the peritoneum or cutting a single blood-vessel, so that the operation was practically bloodless. The bladder was easily detected by the soft feeling of fluctuation it gave to the fingers, and by the circular arrangement of its muscular fibres. After transfixing it with a curved needle, threaded with strong chromic catgut, the water began to run out along the thread. I then made an incision into the bladder about three-quarters of an inch in length, introduced a small curved forceps through the opening, and without any difficulty extracted the stone—a uric acid one, weighing $18\frac{1}{2}$ grs. At first the forceps caught hold of the end of the catheter, and so, to avoid this, the latter should be taken out after the bladder is opened. The bladder was washed out with weak carbolic lotion and six sutures of chromic catgut introduced through the muscular coat, taking care to leave out the mucous membrane. Leaving a catgut drain over and in contact with the bladder, the surface wound, with the exception of three-quarters of an inch below, was stitched, dusted with boracic powder, and

dressed with salicylic wool. A soft catheter was left in, and nurse instructed to withdraw the urine by syringe every two hours. Very particularly requested to see that he did not attempt to pass it voluntarily.

At 12 p.m. (seven hours after the operation), his temperature was 99·8° and pulse 90, next day (that is the 14th), the temperature ranged between 98° and 99·6°, and on the 15th between 97·8° and 99°, and pulse, 80.

On the 16th, the temperature ranged between 97·8° and 98·8°, wound looking well, the two upper ligatures cut through but not removed; water to be drawn off every four hours.

On the 17th, temperature ranged between 97·2° and 99°, third and fourth ligatures cut.

On the 18th, temperature 98·4°, pulse 78, and water to be drawn off every six hours. Up to this time, that is the fifth day, the temperature never exceeded 99·8°, and twenty-four hours after the operation was practically normal. On the afternoon of this day, however, I was telephoned for, when I found that at 1.30 p.m., five hours after having had the water drawn off, he suddenly complained of a sharp pain over the bladder, with a desire to pass water. Before the catheter could be introduced, he passed a little water voluntarily, and the remainder being taken away was found to be stained with blood. As the bowels had not yet acted, a dose of castor oil and later on an enema were given, and to relieve the pain in the hypogastric region which still continued, an ice-bag was supplied, which gave immediate relief. For the next few days the water was bloody, and he passed several small clots of blood. The temperature ranging between 98·4° and 100·6°. On the 20th he was allowed for the first time to pass water naturally, and ever afterwards he continued to do so freely enough.

On the 23rd, the water was free from blood, but for a week or so was cloudy and somewhat offensive, which was remedied by the daily washing out of the bladder with weak boracic lotion, and the internal administration of benzoate of soda.

After the 23rd, the temperature gradually came down to normal and remained so till the end.

As regards the abdominal wound the upper part healed by the first intention, and the lower part was entirely closed by the 28th. No urine ever came by it and the catgut drain was removed on the fourth day.

On the 9th May, a few drops of pus gathered round the site of a ligature, but gave no trouble, and on the 18th day he was discharged quite well.

His diet consisted of milk and barley-water all through. An addition of chicken broth or beef tea was followed on two occasions by slight

cloudiness of urine and then were afterwards entirely discontinued.

In connection with this case I would venture to make the following remarks:—

1. The catheter used for closing the urethra during the operation should have been removed when the bladder was opened.

2. Before the bladder was opened it should have been transfixed by two threads, one on each side, and the incision made between.

3. The water should have been withdrawn for at least a week, at first every two hours and afterwards every four. Five days after the operation the patient was doing and feeling so well, the temp. and pulse being for three or four days previously normal, that I ordered the nurse to withdraw the water every six hours. I was confident the bladder had healed by the first intention, but the over distention was too much for it and that it was over distended there can be no doubt, for at the time there were about 11 oz. of urine in the bladder, and the consequence was that blood appeared in his urine that afternoon and gave us the only real trouble we had in connection with the after-treatment. This, however, did not shake my confidence in the principle of the treatment and believe rather that the error lay in not having had the water taken away as often as the wounded bladder demanded and required.

4 Maxwell Place, Ann St., Brisbane,
July, 1888.

PROCEEDINGS OF SOCIETIES.

MEDICAL SOCIETY OF QUEENSLAND.

THE monthly meeting for July took place on the 10th July, at 8.30 p.m., in the School of Arts, Brisbane.

Present:—Drs. Little, Hill, Taylor, Ellison, Hare, W. S. Byrne, Bancroft, Shout, Hardie, Owens, Thomson, and Love.

EXHIBITS.

DR. LOVE showed a boy with a large erectile tumour in the parenchyma of the left cheek. There was no discoloration of the skin externally, but the buccal mucous membrane was thrown into folds with large papillæ upon them. It occasionally swelled up and looked as if about to suppurate, but it had never done so. It had existed since birth. Some of the members thought it nævoid in character, and suggested electrolysis.

DR. ELLISON remarked that he had had a similar case, which had yielded to the use of red iodide of mercury ointment.

DR. BANCROFT also remarked upon similar cases he had met with in the lip and palm of the hand.

DR. OWENS showed an abdominal tumour which

sprung from the uterine fundus, and which he had removed that day.

DR. BANCROFT showed, under the microscope, the living embryo of filaria of the dog. He afterwards had the dog killed with chloroform, and demonstrated the adult worms in the right auricle and pulmonary artery. In the human species the embryonic worm had a distinct sheath round it, which was absent in that of the dog. The filaria of the dog was, moreover, more active.

The minutes of last meeting were read and confirmed.

NEW MEMBER.

A ballot was taken for Henry F. Forbes, M.B., C.M., Aberdeen, of the Brisbane Hospital, who had been nominated by Drs. W. S. Byrne and F. E. Hare. Dr. Forbes was elected a member.

PRESENTATION TO THE HON. SECRETARY.

THE PRESIDENT wished to mention a matter which had been settled since their last meeting. At the last meeting, in the temporary absence of the Secretary, it was proposed to mark the appreciation of the Society for the efforts of the Secretary, and he thought that Dr. Love's recent marriage afforded a good opportunity of doing so. It had been proposed to make a grant from the funds of the Society and to supplement this with private subscriptions from the members. The proposal had met with general approval, and as a result they were able to present Dr. and Mrs. Love with a very handsome silver salver, suitably inscribed, and a tea and coffee service.

THE SECRETARY acknowledged with great pleasure the kindly feeling which had prompted the members to recognise his interest in the work of the Society, and desired to give them his most hearty thanks for their more than handsome gift.

PAPERS.

DR. HARDIE then read his paper on "The Supra-pubic Operation for Stone in the Bladder," with notes of a case (which appears elsewhere in our columns).

Considerable discussion followed, in which Drs. LITTLE, BYRNE, BANCROFT, THOMSON, and LOVE took part.

DR. LOVE then read a paper "On the Treatment of Stone in Children, with special reference to Litholapaxy," together with notes of a case (which appears elsewhere in our columns).

MEDICAL SECTION OF THE ROYAL SOCIETY OF N. S. WALES.

Monthly meeting held in the Society's Rooms, Sydney on June 16, Dr. Knaggs in the chair.

Present: Drs. Scot-Skirving, Eichler, Goode, Munro, Roth, Sydney Jones, Crago, Mander Jones, Ross, Lyden, Marsano, Garrett, McCulloch, Fiaschi, McLaurin, Worrall, Martin, Ellis, Brady, McCormick, and Jenkins.

The minutes of previous meeting having been read and confirmed, Dr. REUTER ROTH read a paper on "Rational Infant's Clothing," and dressed a large doll with the garments. Dr. EICHLER made a few remarks.

DR. GOODE exhibited a boy whose left tibia had been removed by him for necrosis; the periosteum had been left, and new bone thrown out.

DR. CRAGO instanced several cases he had treated with less satisfactory results.

DR. MCCORMICK showed, for Sir Alfred Roberts, a man with ununited fracture of the left humerus; several attempts had been made to raise the ends without success; the man has great control over the arm and is able to drive a cab.

A letter from the Dean of the Faculty of Medicine, with reference to the attendance of the Curator of the Museum at the meetings, was read.

It was moved by Dr. SYDNEY JONES, and seconded by Dr. GOODE, and carried unanimously—"That the Curator be allowed to attend to secure such specimens members might wish to be preserved in the University Museum."

The meeting ended at 9.15 p.m.

Monthly meeting held on July 20, Dr. Knaggs in the chair.

Present: Drs. O'Reilly, Anderson Stuart, Kendall, Graham, Roth, Hankins, Lyden, W. Chisholm, Fairfax Ross, West, (Stokes, Purcer, visitors), Sydney Jones, Garrett, Wilson, E. G. Blaxland, McAllister, Crago, D. D. Rutledge, McCormick, Eichler, Foreman, Martin, Worrall, Brady, Fiaschi, Faithfull, Steel, Carruthers, and Jenkins.

The minutes of previous meeting were read, and Dr. GRAHAM then read a paper on "Exophthalmic Goitre," and exhibited the patient—a man who had been under observation in the Hospital five weeks.

DR. FAIRFAX ROSS described a case under his care at St. Vincent's Hospital. Dr. SYDNEY JONES thought the sympathetic nerves were at fault in this disease, and quoted a case of his in which diarrhoea was a prominent symptom.

Drs. KNAGGS and FAITHFULL, also joined in the discussion.

DR. JENKINS read a paper on "A case of Aortic Regurgitation, followed by right hemiplegia and aphasia, and by partial arrest of the circulation in the left subclavian, axillary, tracheal, radial, carotid and other arteries." The patient had been a sailor on H.M.S. "Wolverine," and had had syphilis thirteen years ago. Hardly any pulsation could be felt in the left radial, subclavian or carotid arteries, and there were pressure symptoms, such as dysphagia, aphonia, and dilated left pupil, leading to the belief that there was probably an aneurism of the transverse part of the arch of the aorta, deeply situated, and between the orifice of the right innominate, and left carotid and subclavian.

DR. ROSS, who had also seen the patient before, doubted whether syphilis was the cause of his heart disease.

DR. CARRUTHERS believed that in a large number of cases of aneurism, a distinct history of syphilis could be traced.

The patient was exhibited.

DR. FAITHFULL read some notes on the treatment of "Migraine," and gave short histories of a few cases. He had found great benefit from the use of antipyrin in ten grain doses, repeated if necessary in half-an-hour. In certain cases he found a combination of antipyrin with bromide of potassium or iodide of potassium, very useful; and also antifebrin and "Salol." (See page 270.)

DR. SYDNEY JONES did not find antipyrin so generally useful as "Citrate of Caffeine" in migraine.

DR. FAIRFAX ROSS had seen unpleasant symptoms after prescribing "antipyrin." He preferred "antifebrin."

DR. HANKINS personal experience of "antipyrin" was most satisfactory; he had, however, seen bad symptoms from its use in others. He had tried guarana, caffeine, and cocaine, without benefit.

Drs. ROTH, KNAGGS, and JENKINS joined in the

discussion. Dr. ROTH found "head-tapping" useful in some cases.

Dr. McCORMICK read notes of a case of "Malignant Tumour of the Thyroid in a Woman aged 43." He gave a minute description of the operation he performed. The tumour was closely adherent to the trachea, but was removed without injuring it. The patient was now convalescent.

Dr. ROTH exhibited a "scolimeter," or instrument for measuring curvatures of the spine.

It was decided that at the next meeting the treatment of typhoid fever should be discussed.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE 72nd General Meeting was held in the Royal Society's Room, Sydney, on Friday, July 6, 1888, at 8.15 o'clock.

Present:—Dr. Chambers, President (in the chair), Drs. Fiaschi, Sydney Jones, Hankins, Sir Alfred Roberts, Drs. Wm. Chisholm, Manning, Garrett, McCulloch, Clubbe, Warren, W. J. O'Reilly, Fisher, Megginson, Both, A. T. O'Reilly, E. F. Ross, Worrall, Martin, McDonagh, Twynam, Kendall, West, Crago, McCormick, Faithfull, Brady, G. A. Marshall.

Visitors:—Drs. Jones, Wilson, and Hinds, Messrs. Mills and Hinder.

The minutes of the previous meeting were read and confirmed.

The PRESIDENT announced the election of the following new members:—Drs. Lamrock, A. T. O'Reilly, Shand and Lyden.

The Hon. Secretary (DR. SCOT-SKIRVING) stated that the Council had had under consideration the case of the widow of the late Dr. Jockel, of Richmond, and had resolved that it would be better for some member of the Branch, not being a member of Council, to take up the matter of collecting subscriptions, as in a previous case great confusion had occurred through gentlemen forwarding their subscriptions to the Branch and to the Relief Fund in the same cheque. Under these circumstances the Council would be glad if some gentleman would undertake the duties of Hon. Secretary to the Fund.

DR. W. J. O'REILLY proposed "That Dr. Garrett be appointed Hon. Secretary to the Jockel Relief Fund." Seconded by Sir ALFRED ROBERTS, and carried.

DR. CHAMBERS exhibited a specimen of an extra-uterine foetation, and explained the case.

DR. WILSON said it gave him great pleasure to be present at the meeting. With regard to the points raised by Dr. Chambers as to the clinical features of the case, he (Dr. Wilson) had nothing to say. He then spoke at some length on the pathological features of this case, and said he considered that the septic peritonitis probably owed its origin to the local extension of mischief up the patent fallopian tube from the sloughy and putrid interior of the uterus. He mentioned the analogous case of the septic abscess, produced after devitalizing a testicle, and introducing septic material into the blood. The parallel condition in Dr. Chambers' case being the septic condition of the uterus and the devitalized macerated foetus, with its cyst and other contents.

DR. WORRALL said he was much interested in the case brought forward by Dr. Chambers, and the interest was considerably increased by Dr. Wilson's remarks on the *post mortem* examination. He (Dr. Worrall) could

not agree with Dr. Wilson as to the septic matter being introduced from without, he thought it more likely to have occurred through the bursting of the tumour. He also thought it would have been better to have opened the abdomen and removed the tumour than to take the risk of bringing on premature labor.

DR. FIASCHI asked Dr. Chambers the following questions:—

1st. Has Dr. Chambers, in his large experience, ever known any case of death from peritonitis following the apparently recent rupture or ulceration of the involucre of a lithopædion or other form of encysted foetus?

2nd. Would Dr. Chambers have a portion of the macerated foetus, part of the nervous centres in special, chemically analysed for the detection of some poisonous ptomaine?

3rd. Had there been any foci of septicæmia in the surroundings of the patient.

DR. G. E. TWYNAM said he would like to ask one or two questions about this case,—1st. As to whether it would not have been advisable to operate when it was found that the tumour was (to use Dr. Chambers' expression) anchored. He (Dr. Twynam) had been reading a discussion which had taken place in the Obstetrical Society, in which it was agreed that you should operate before adhesion had formed; for, if you allowed the case to go on, the adhesion would become greater and the hæmorrhage would necessarily be greater when the operation was performed. There was one point about the theory set up by Dr. Wilson as to the passing of the septic matter up the patent fallopian tube, it appeared to him (Dr. Twynam) that the tube, after so long a time, would be completely stopped up at the distal end.

DR. WILSON replied that he examined it and it was closed.

SIR ALFRED ROBERTS suggested that although there might be the two forms of inflammation—1st. The simple acute inflammation, and 2nd, the septic inflammation, it was quite possible for the former to merge into one and become thoroughly septic.

DR. SYDNEY JONES said that he had, by the kind permission of Dr. Jones, of Ashfield, seen this case two years ago. She was then healthy, and to use her own expression, "Did not want any doctor." He (Dr. Sydney Jones) found a large tumour on the left side, freely moveable, the size of a uterus at the fourth or fifth month, and apparently without adhesion. She was at that time unimpregnated. It is no doubt easy to be wise after the event, and it is not difficult to see that abdominal section would have been the better plan in this case.

DR. CHAMBERS, in reply, thanked the members for their attention and criticism of this case. It was as Dr. Jones had said, easy to prophesy after the event. With regard to Dr. Wilson's remarks, peritonitis had set in before the woman was touched, and that peritonitis was not septic. As to the idea of shirking an operation, in the earlier stages of the case, that was absurd, as the woman did not seem to think that she needed anything doing to her, she was to all appearances enjoying good health, and one could not force her to undergo an operation. As to Dr. Fiaschi's suggestion to have a portion of the exhibit analysed, he would do so. In difficult cases like this your only course is to do the best under existing circumstances.

MR. G. T. HANKINS explained a case of excision of the knee joint and exhibited the patient, who was examined by the members present.

DR. ROTH exhibited some "Sanitas" preparations.

SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

MONTHLY MEETING held at the Adelaide Hospital, at 8.30 p.m., on Wednesday, July 25, 1888.

Present: Dr. Stirling, President (in the chair), Messrs. Clindening, Hayward, Humphrey, Martin, Mitchell, Anstey Giles, and Drs. Gardner, Davies-Thomas, Symons, Lendon, Swift, and the Honorary Secretary. Dr. Evans was present as a visitor.

The minutes of the Annual Meeting held on June, 19, were read and confirmed.

DR. GARDNER, by permission, drew the attention of members to the case of Dr. Addison, a medical practitioner residing in Mitcham, who at an advanced age and in poor circumstances, was quite unable, from sudden and severe illness, to continue in practice. He was formerly a member of the Branch, and had resided in South Australia for several years. DR. DAVIES-THOMAS moved, that representation be made to the Trustees of the Wyatt Benevolent Institution, and to the Trustees of the Medical Benevolent Fund, calling attention to the case, and recommending it as worthy of assistance. Seconded by MR. HAYWARD, and carried unanimously. DR. MITCHELL moved, that a subscription list be opened, that members might have the opportunity of giving some immediate help. Seconded by DR. LENDON, and carried.

NEW MEMBERS.

Messrs. William Withers Fwbank, M.C.R.S.E. et L.S.A., of College Town, proposed by Drs. Gardner, Stirling, and Anstey Giles; Frederick William Ellison, M.R.C.S.E. et L.S.A., of Glenelg, proposed by Messrs. Clindening, Hayward and Dr. Thomas; Arthur H. Gault, M.B. LOND., L.R.C.P. LOND., et M.R.C.S., of Lower Mitcham, proposed by Dr. Verco, H. H. Wigg, and Dr. Stirling, were balloted for, and elected members of the British Medical Association, and its South Australian Branch.

EXHIBITS.

DR. GARDNER showed a woman who had under his care made a perfect recovery, after a wound of the knee-joint, followed by acute suppurative inflammation. He had incised the joint freely; all the movements of the joint were now unimpeded. Also a young woman, the subject of spasmodic torticollis, in whom he had divided and removed portions of the spinal accessory nerves, and also portions of the anterior cervical nerves, with considerable benefit.

CARD SPECIMEN. EXCISION OF HIP JOINT.

By Drs. T. K. and C. W. Hamilton (Laura). Patient, aged 9½ years. Disease of 2½ years standing, acetabular and femoral, both extensive; acetabulum freely gouged, pus filling the joint, and distending a sac as far as middle of femur.

The SECRETARY read, in Mr. Bickle's absence, a paper on Erythema Nodosum, accompanied by unusual eye symptoms (*vide* page 276), on which DR. SYMONS made some remarks. He had not met with the peculiar association of symptoms detailed by Dr. Symons.

DR. GARDNER read a paper on Nephro-lithotomy, by Terrier's trans-peritoneal operation (see page 278).

The PRESIDENT, and DR. DAVIES THOMAS spoke on the subject. DR. THOMAS was in favor rather of Langenbeck's incision.

D. GARDNER read a paper on supra-pubic operations, for stone in the bladder, and other diseased conditions of that viscus (see page 275); on the motion of DR. LENDON, discussion on the paper was deferred to the next (August) meeting.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, AUGUST 15, 1888.

EDITORIAL.

THE DISPOSAL OF THE DEAD.

From time to time some circumstance is brought under public notice which incontestably shows that some change in the present method of disposing of the dead must come at no distant date in countries where the population in any degree is becoming dense. The following report, made by Dr. Ashburton Thompson, Chief Inspector of the Board of Health, of his visit to the Necropolis at Rookwood, the principal cemetery for Sydney and its suburbs, on July 20, 1887, which has recently been published as a portion of a return made by order of the Legislative Council of New South Wales:—

"The western fence of the cemetery runs alongside the road running to the reformatory buildings. Turning out of it is another short road, which has on one side five houses, of which that nearest the cemetery is inhabited by Mr. Lawrence; the three next belong to him, the fifth belongs to some other person. On the other side of the road is a stonemason's yard, a dwelling house is attached to it, but this has a frontage to the cemetery boundary road. Mr. Lawrence took me to a plot fully occupied with a large number of graves; these are in the Roman Catholic portion; they are the graves of paupers, and the plot referred to is within 100 yards of Mr. Lawrence's dwelling. The slope of the land is towards the houses. Opposite to Lawrence's house is a gate of entrance. Alongside this gate is a sump, perhaps two feet square, which catches any silt which may be washed down from the various cemetery gutters which may converge to it. The overflow from it runs straight out to the first mentioned road, and is conducted in the direction of fall by a spaded gutter not more than ten yards long. The gutter then simply ceases on the road surface, and Mr. Lawrence considers that in wet weather his premises are kept damp by this water, which, however, cannot run across the slightly raised road, but doubtless flows under ground to them. This water must, I believe, be polluted by the bodies buried a little higher up. We proceeded to the graves. Mr. Lawrence said that burying began at this part of the cemetery three or four years ago. Since last summer the graves have been reopened at

the rate of two or three a day, and another body put in. From observations, he says that the rope used to lower the second coffin did not slip more than a foot through the men's hands before the bottom of the grave was reached.

I took a pointed stick and probed several of the more recent mounds, and I reached what I do not doubt was the coffin-lid, at a depth below the surface of from 18 to 24 inches. I name the following graves, which happened to have pegs immediately opposite to them:—No. 795 appeared to have the coffin 24 inches below the top of the mound, or 18 inches below the surface; No. 176 appeared to have the coffin 24 inches below the surface. These were not graves specially pointed out by the complainant, but were selected by me for the reason given; there were several others near by, of which I ascertained, substantially, the same facts. Along the feet of one row of such graves there ran down the incline a sort of gutter, and from the foot of each of several graves to the gutter was a streak of soil having an appearance which showed that a stream of fluid had run over it.

Mr. Lawrence said that during the past summer there had been, on still nights, a very offensive smell proceeding from these graves, in which, at that time the bodies were single. This was corroborated by two trustworthy persons, one of whom is a householder adjacent. The other said that he had already entered into negotiations with Lawrence for the purchase of his house, but had broken them off on seeing the second series of bodies put in, and as described. They apprehend that the neighborhood, next summer, will be uninhabitable, and I should be surprised if that does not turn out to be the case.

I went to the office, and saw Mr. King, the Superintendent of this part of the cemetery. I told him that I had satisfied myself that there were three coffins not more than 18 inches below the surface, and he did not contradict me. I asked him whether the reopening of the graves was on his own responsibility, and he said that he had always to get instructions from the trustees when this course seemed necessary to him. I asked him for a copy of the regulations guiding his operations, and he showed me a framed copy. I learned from that that graves are to be six feet deep, and are not to be reopened within less than six months from the first interment. I then pointed out the following dilemma: As 14 inches may be taken as an average depth—but a liberal allowance, I believe, for shells—of coffins, and as I have reached a coffin just 18 inches below the surface, and as he had already told me that his instructions for reburial (to uncover the first coffin and place the second on its top) are observed, one of two faults must have been committed. Either the grave was not originally six feet deep, or else there are more than two bodies in the graves mentioned. To this, as to other remarks, he made no reply. I took a sample of the mud apparently issuing from a grave, and I have transmitted it to the Government Analyst. I recommend that a sample of water in the sump should be taken for analysis, a sample from Mr. Lawrence's underground tank, and another from that attached to the premises next to his.

I am of opinion (and the evidence supports it) that six feet is an entirely insufficient depth for bodies near the boundary of a cemetery on clay soil. The second body in each of these graves must be removed and decently interred. Wherever earth burial is adopted the sub-soil water outside the bounds of the cemetery becomes polluted, in what is perhaps the most repulsive way of all; and as this water travels under houses erected in the neighborhood, it seems that all cemeteries

should be surrounded by a neutral zone, which is at present quite inadequately represented by the 60 or 100 feet reserved usually inside the boundary fence. Practically this is impossible, for such a zone to be of practical use must be usually at least half-a-mile wide. The alternative is to dispose of the dead in some other way; but, at all events, the air may be kept from such gross pollution as is betrayed by offensive smells, by burying sufficiently deep, and regulations to ensure this should be enforced without delay."

On this report action was promptly taken by the Board of Health, a layer of charcoal being put over each of the graves, and this covered with a mound of three feet of earth. This course was adopted as being preferable to the removal and reinterment of the bodies.

The management of this cemetery was supposed to be all that was good and trustworthy, but the report shows what abuses may come about where all is supposed to be correct. The population about the cemetery is not very numerous at present, but it is increasing daily, and the health of every inhabitant is in some peril in the close neighbourhood of a cemetery, even if properly managed; how much more so if careless and shallow burial takes place.

The true remedy is the introduction of cremation, and we can only express the hope that the Cremation Society, the preliminary steps for the formation of which have been taken, will soon become an established fact, and that it will quickly be in a position to carry on the destruction by fire of the bodies of persons desirous that their remains shall be disposed of in that way.

It may possibly be advanced by the opponents of the system that if it had been in vogue during the last few years, some bodies which it has been found necessary in the administration of justice to exhume would have been destroyed, and the two disinterred during the course of the inquiry into the alleged case of poisoning at Botany would possibly be quoted as examples. This case being *sub judice*, we cannot go very fully into it, but would merely remark that very little positive evidence seems to have been adduced by these disinterments, and that if any proposition had been made at the time of death to cremate them, the regulations proposed in the late bill in the Legislative Council, which will be a part of the rules of the future Society, would probably have led to the detection of poisoning if any poisoning took place, before the body was burnt, and at a time when it might have been possible to have sheeted the crime home to the wrong-doer. The present system of Registration of Deaths in New South Wales is so defective, and enforces so few safeguards to life against secret crime, that we have no doubt that many deaths from poison and other felonious means take place every year in that

colony, the bodies being disposed of by the murderers with ease, and with but the smallest chance of the detection of the true cause of death. This was made manifest by the report of the Select Committee of the Legislative Council on Registration, made in 1886, the evidence given by many witnesses before it making startling revelations. The necessity for a new law has been pressed on the present Government, and a Bill to bring about the necessary reform was introduced in that House by the editor of this journal, which, however, was ruled out of order, because one of the clauses said that *the necessary books should be provided at the public expense*, and this, as it involved the expenditure of public moneys, necessitated the Bill being withdrawn. It is one, however, that is essentially one of public policy, and should be a Government measure, and not be introduced by a private member. As it is a matter concerning the public safety, and not relating to the erection of a "State House," or the filching of the name "Australia" for the special use of New South Wales, it is useless to expect that the necessary steps will be taken by Sir Henry Parkes,—so the colony must perforce wait the advent of his successor.

LETTERS TO THE EDITOR.

A CORRECTION.

(To the Editor of the A. M. Gazette.)

DEAR SIR,—In the report of the discussion on Dr. Fiaschi's paper on Internal Urethrotomy, some slight errors are present in the rendering of Dr. Faithfull's remarks. What that gentleman did say is as follows:—He (Dr. Faithfull) said "it gave him very much pleasure to be present, and to hear Dr. Fiaschi's paper read, as he had assisted at several of the operations mentioned. He (Dr. Faithfull) did not think it was absolutely necessary to divide a stricture completely. He thought that, having cut through a stricture sufficiently to admit the passage of a full-sized sound, that afterwards the cicatricial tissue became absorbed. Believed fever was very often brought on by the patient passing water too soon after the cutting operation, or the passage of a sound afterwards, for in several cases in which he had had fever he had put it down to the urine passing over the cut surface before it had time to become glazed over with blood clot. He now always made patients pass water prior to performing any cutting operation or passing of a sound afterwards, and cautioned them not to pass water for six hours. Since doing so he had not met with any rise of temperature. Sometimes he found it necessary to divide the external meatus before passing a full-sized sound."

I shall be obliged if you will insert this correction.

Yours faithfully,

R. SCOT-SKIRVING,

Hon. Secretary N.S.W. Branch, B.M.A.

Sydney, July 18, 1888.

A NEW SYPHON STOMACH PUMP.

(To the Editor of the A. M. Gazette.)

SIR,—I have had made for me, in Melbourne, a new syphon stomach pump, similar to a seamless Ingram's enema syringe, but with a stomach tube attached in the place of the rectum pipe, for simplifying the process of washing out the stomach when undertaken for the relief of certain symptoms. All other syphon tubes fail in certain particulars which this one is intended to obviate. For instance, much time and patience is lost in causing the fluid to commence running into the stomach. This is here accomplished by compressing the tube between the mouth and the bulb, creating a vacuum in the latter, and relaxing as soon as the fluid commences to rush into the bulb. When the current is to be reversed, it sometimes happens that the lumen of the tube gets plugged from some cause or other; in plain tubes this can only be rectified by drawing the tube right out, clearing and reinserting it, a procedure by no means clean or pleasant to either operator or patient. In my syphon it is only necessary to aspirate slightly by creating a vacuum in the bulb, or to force a little fluid downwards by an injecting movement, and the tube is cleared at once. In Tosswill's syphon there are too many screw-joints and washers to make it of practical service in Australia, and the hot weather soon splits the tubing, which is not corrugated, and loosens the joints and washers so that the whole system may, by the admission of a little air, become inoperative at a critical moment and create a bad impression in the patient's mind. I find, also, that the slightest alteration in the calibre of any part of a syphon system, at least in the case of the stomach syphons, is sufficient to interrupt the flow of the current within it, in fact, such a syphon will not work under any conditions. In my tube the calibre remains constant throughout. There is as much difference between my tube and Tosswill's syphon stomach pump as there is between Ingram's and Higginson's enema syringes. In fact, the former being in one piece suggested to me the idea of having a stomach tube made on a similar principle, and I have found it to work admirably up to the present. In appearance the two syphons differ considerably, and I need hardly point out the advantage of being able to show a timid patient a neat rubber tube instead of a cumbersome arrangement of tubes, screws, and bags like Tosswill's pump, which, perhaps, will not even work when the patient has it down his œsophagus. Having had to treat a large number of cases of gastric affections since 1886, in which washing-out was indicated, I felt the necessity of devising some better implement

than those offered me by instrument makers, and I have great pleasure in recommending my apparatus to those who have occasion to wash out the stomach, for the reasons above mentioned. Indications for this line of treatment have been laid down elsewhere by myself and other writers on the subject. They are now so well known that it will not be necessary to reiterate them here, but at some future date I intend again to place the results of my treatment so far before the profession. Suffice it to say that I have not experienced the difficulty anticipated by various writers with English patients, and every case I have treated up to the present has been cured without relapse.

I am, &c.,

F. W. ELSNER, F.R.C.S.I.

189 Church-street, Richmond (Melbourne).

July 9, 1888.

THE MEDICO-ETHICAL ASSOCIATION OF NEW SOUTH WALES.

(To the Editor of the A. M. Gazette.)

SIR,—At a meeting of the medical profession held in Sydney some months ago the desirability of forming a "Medical Defence Fund," out of which the expenses of members subjected to litigation might be defrayed if the case were deemed deserving, and also assistance be rendered to necessitous members or their families, was decided upon, and a committee was appointed to draw up the rules of such an association. On July 5 a meeting of the profession was again convened to consider the rules and bye-laws proposed by the said committee. It was, however, at once observed that the rules and bye-laws proposed had so little to do with the subject of such a "Defence Fund,"—but were really those of an ethical association—that it was found necessary to change its name from "Medical Defence Fund" to "Medico-Ethical Association," and thus the much-needed "Defence Fund" was lost in the formation of a quite unnecessary—inasmuch as its work is fully covered by the medical and scientific associations already in existence here—ethical association, which thus sneaked into formation under the popularity of the "Defence Fund."

Even as a medico-ethical association, I consider the rules passed to be most arbitrary and unjust; nor do I consider that it would be desirable, even if it were possible, to enforce, in a young country like this, where the conditions and usages of life are so different, a code of ethics such as might be desirable in Great Britain.

Fully to discuss all the rules and bye-laws would trespass too much on your valuable space, but I will briefly refer to a few of them.

Rule 6: "All members of the present societies (Medical Section of Royal, and British Medical) shall be original members, without ballot, on payment of entrance fee and subscription on or before January 1st, 1889, and signing the agreement to abide by the rules of the Association."

What rights does the membership of these societies give to *exclusion from ballot*? Should not all registered and legally qualified medical men, against whom no valid objection can be made, enjoy the same privilege? Most certainly yes, I say. I believe all the members

of the committee belong to one or both of these societies. Do they not seem, then, to be legislating for their own advantage, and to the prejudice of the profession generally? Can it be that these models of what a medical man should be, fear a ballot?

Rule 7 provides that a "medical man, desirous of joining the Association, must be balloted for by the Council, five to form a quorum, and one black bean in four to reject." Now that, I take it, means that if two of the Council are opposed to the admission of a candidate he will be rejected, and I submit that in a place like Sydney, where there is so much professional jealousy, and where personal likes and dislikes might be gratified on such occasions, such a test is little short of an absurdity.

I submit that every registered and duly qualified medical man, against whom there is no valid objection, has an equal right to admission *without ballot*, on making the necessary payments, and signing the rules.

Rule 34 provides that a "member may be expelled from the Association by a vote of three-fourths of the members, 21 members being present," and in such an event "no member shall meet the expelled member in consultation."

Now, according to the rules, the offences for which a member may be expelled are such as not only are not wrong in themselves, but may meet with the direct approval of the one-fourth of the members in the minority, who are thus called upon to lay aside their own consciousness of what is just and right to their fellows, and act in blind obedience to the dictum of the majority. Such boycotting is an interference with the rights of the individual which should be resisted to the bitter end, and will not, I think, be brooked by men of honour and independence.

Bye-law 1 provides that "no member shall practise as a homœopath." Now, whether homœopathy be right or wrong it is not for me to say, but I do say that it is practised by many qualified men of undoubted ability and uprightness, who do so under the conviction that they are thereby rendering the greatest service they can to their fellow men, and I think that to prevent members from meeting such men in consultation, if they choose, shows a spirit of intolerance unworthy of an honourable profession. If this were called an "allopathic" association then it would be quite right to exclude homœopaths from membership, but even then I consider it would be intolerant and arbitrary to prevent the members meeting them in consultation if they choose.

Bye-law 2: "No member shall by advertisement, circular, card, or placard, solicit private practice."

This bye-law meets with more sympathy from me, but still, if carried out in its integrity, would necessitate the removal of every doctor's door-plate. It seems to me that advertising must either be entirely prohibited in every form, and under every pretext, or then be left to the individual taste and judgment of each medical man; and, unless it be offensive in itself, or to public decorum, I think it is practically impossible to draw the line. If one medical man chooses to advertise his removal, resumption of practice, or anything else, for—say a week, well, that suits his purpose, and he is satisfied. But another wishes to advertise for a year, which he deems to his advantage, then I consider the latter has as much right to advertise for a year as the former for a week.

This is especially necessary in the case of specialists, for certain medical men have admitted superiority over their colleagues in certain departments of medicine and surgery, to which they have given special attention, and in which they have more extended

experience, and which many even decline to treat. How, then, are the public to know such men? and how are even their colleagues in the country to know them? Patients would have, in the first instance, to consult some general practitioner, who would have to direct them to whom they should apply. Thus the patient would be subjected to delay and unnecessary expense, even if he had sufficient confidence in the general practitioner to accept his decision as to the best specialist to consult. Moreover, the general practitioner's choice might be influenced more by personal feeling than by the capability of the specialist, and thus again the patient might suffer.

By-law 4: "No member shall give testimonials in favour of any patent or proprietary medicines, or other articles, or in any public way recommend their use." This is, I think, arbitrary and absurd. Any man is at perfect liberty to give any testimonial he thinks proper to any preparation of which he approves, in my opinion. This is and has been done by the most eminent men in the profession all over the world, and for a few medical men in Sydney to constitute themselves an authority to pass judgment on all their colleagues over the world, on men who are in every way infinitely their superiors, is, to say the least of it, eminently ridiculous.

By-law 5: "No member shall keep an open shop, or sell patent medicines, &c." Under the existing conditions of many country districts the keeping of an open shop might be a decided advantage to the public, and need not necessarily, I think, be any degradation to the profession.

The prohibition to sell any patent medicines would debar any member who did his own dispensing, and charged for his medicines, from using certain patent medicines which have the sanction of many eminent men in the profession, and which he may consider likely to do his patients more good than any other; and if he did so, not only would he be liable to expulsion from the Association, but all members, whether they disapproved of his action or not, would be compelled to decline to meet in consultation such colleague, which, to my mind, is as arbitrary as it is unjust.

Not content with even such arbitrariness, however, this tribunal takes upon itself the duty of judging members of the profession outside its privileged fold who dare to have the courage of their own opinions, and boycott them from all communion with their colleagues (*vide* Section II.) Truly the Inquisition is again revived! If such an association should succeed in forming itself, I do not hesitate to say that, instead of forming a "bond of union among members of the profession," it will more than any one other thing produce bitterness and dissension among them, and sow discord where hitherto have existed harmony and union.

Such an association would boycott a large number of the most eminent medical men all over the world, and if formed on the rules proposed, which I can scarcely think it possible the medical profession in New South Wales would submit to, the honour, it seems to me, would consist in exclusion from its hallowed pale.

What is wanted, and urgently wanted, is the formation of a "Medical Defence Fund," from which necessitous and deserving cases might be assisted, without subjecting the recipients to the indignity of sending the hat round, which is now being done for, I think, the fourth time within twelve months. Let a defence association be formed, to which all duly qualified and registered medical men, against whom no valid objection can be made, may belong, with an entrance fee of £3 3s., and an annual subscription of £1 1s., and let only such rules as are necessary for the management and

distribution of the funds be drawn up, and in three months there ought to be a defence fund worthy of the profession, and sufficient to meet all just claims.

Let a spirit of harmony and charity pervade the movement, rather than the cry, "God, I thank thee that I am not as other men!"

I remain, yours truly,

ALEX. PATERSON,

A.M., M.D., M.R.C.S.E., F.R.C.S.E.

29 Bligh-street, Sydney, July 29, 1888.

[We agree with some of the remarks made by our correspondent, but as regards the whole subject we fear that we can hardly accept him as an entirely disinterested critic.—Ed. *A.M.G.*]

GRATUITOUS ATTENDANCE ON MINISTERS OF RELIGION.

(To the Editor of the *A. M. Gazette*.)

SIR,—Is there any breach of medical etiquette in charging a Minister of Religion a fee? What is the rule in the matter?

Information concerning the above will be gladly received by

Yours truly,

TASMANIA.

4th July, 1888.

[There is no rule as to gratuitous attendance on Ministers of Religion, and therefore there can be no breach of professional etiquette in charging them as ordinary patients. In consideration of the small income which they generally derive from their calling, it has become a generous custom on the part of medical men to attend them and their families without charge, but it is in no way obligatory, and every medical man is at perfect liberty to take his own course in every case as it arises. This favour to clergymen has been so general and is of such old standing, that we regret to say that many of the recipients have the bad taste to act as if what is a purely generous act, were an established right which they could claim; but this, as a rule, occurs in the case of uneducated men who have been pitchforked into the various churches by some accident.—Ed. *A.M.G.*]

Medical Books at PUBLISHED Prices.

MR. BRUCK, Medical Bookseller in Sydney, begs to inform the profession that he is selling all medical books at PUBLISHED prices. An assortment of the latest works has just been received by the Pacific R.M.S. "*Mariposa*." A list of some of the books in stock, with published prices attached, will be found in this issue.

ABOUT the end of August MR. BRUCK will receive a full supply of *Erichsen's Science and Art of Surgery*, 9th ed., with 1,025 illus., 2 vols. (1888), published at 48s.; postage 3s.

WANTED TO PURCHASE.—A GOOD PRACTICE in SYDNEY or SUBURBS; state amount of premium required, and other particulars. Partnership not objected to. Address—F.R.C.S., *Australasian Medical Gazette* Office, 35 Castlereagh-street, Sydney.

SPLendid MICROSCOPE BY ZEISS (almost new), for sale; has four oculars and three objectives (AA, DD, and 2.0 m. m. oil immersion, or $\frac{1}{12}$ in.), fitted with Abbe's condenser, magnifies 1,600 times. Price £50. Apply to Mr. L. BRUCK, 35 Castlereagh-street, Sydney.

THE MONTH.

NEW SOUTH WALES.

At a meeting of the Senate of the University of Sydney, held on July 16, a confidential memorandum was received from Professor Stuart in which he proposed that the present departments of anatomy and physiology should be separated into two distinct departments. After considerable discussion the matter was referred to the following committee for consideration and report:—The Chancellor, the Vice-Chancellor, Dr. Jones, Dr. Benwick, Mr. Stephen, Mr. Macleay, Judge Backhouse and Mr. Oliver.

THE Senate of the University of Sydney has resolved that advertisements should be immediately issued, calling for applications for the position of Lecturer on Ophthalmic Medicine and Surgery, at an annual salary of £50, and stating that the officer appointed would, under the approval of the conjoint board, become an Honorary Medical Officer of the Prince Alfred Hospital, subject to the by-laws, rules and general discipline of that hospital.

THE Government have decided to remove the Quarantine Station from its present situation near Manly, as soon as a fitting permanent site for it can be obtained.

In the *Government Gazette* appeared the following notification of the N. S. Wales Medical Board, dated July 11, and signed by Drs. McKay, O. S. Evans, and Milford:—"The name of Thomas Robert Horton, which was omitted from the annual list published by the Board, is hereby restored."

FROM a return laid upon the table of the Assembly on July 10, it appeared that nine persons died in 1885, 1886, and 1887, whilst under the influence of chloroform, viz., four in Sydney, one in Newcastle, one in Goulburn, one in Albury, one in Wagga Wagga, and two in Petersham. With the exception of two cases, all the persons who died whilst under its influence expired at hospitals, and the juries' verdicts exculpated the medical men who were attending the patients at the time from all blame, stating that due care had been taken in administering the drug in connection with the performance of surgical operations.

WE regret to learn that Dr. T. F. Macdonald, of Prospect Camp, met with a serious accident on Saturday, July 7, while following the Sydney Hunt Club pack in a run to Smithfield. The hounds ran unkindly in following a drag, and during one of the frequent checks, Dr. Macdonald endeavoured to get by a horse ridden by Mr. W. Lamb, of Parramatta, when the beast kicked out viciously, striking the doctor very hard on the right leg and causing a compound fracture. Drs. Cortis and Huxtable, of Sydney, fixed up the injury temporarily, and had Dr. Macdonald conveyed to the Parramatta Hospital, where he was attended to by Drs. Phillips and Bowman, who set the broken limb, and we understand, he is now getting on well.

DR. E. P. ATWATER has commenced practice at Newtown, near Sydney, in conjunction with Dr. J. Kingsbury.

DR. R. BOWMAN has removed from Granville to Parramatta.

DR. M. L. BUTLER has succeeded to the practice of Dr. Protheroe at Burrows.

DR. P. F. CASEY, J.P., of Hay, has been appointed a member of the local Licensing Court.

DR. DANSEY, who, for the last 18 years, has held the position of Health Officer for the City of Sydney, at

a salary of £450 a year, has been dismissed by the Mayor, who intends to appoint a new officer at the reduced salary of £300 per annum.

DR. E. FLORANCE has removed from Picton to Bungendore, 174 miles S.W. of Sydney.

DR. J. A. HAYDEN, late of Muttaborra (Qu.), and formerly of Dimboola (Vic.), has settled at Adelong, a gold-mining township 311 miles S. of Sydney.

DR. C. MCKAY, of Sydney, has been appointed a member of a board to determine the compensation to owners of vineyards to be destroyed under the "Vine Diseases Act."

DR. T. J. MACLOUGHLIN, a new arrival, has settled at Merriwa, 198 miles north of Sydney.

DR. W. S. PARTRIGE has removed from Warren to Mount Hope, the centre of a rich copper-mining district, 440 miles W. of Sydney.

DR. THOS. PRANGLEY, late of Katoomba, has succeeded to the practice of Dr. Henry Ray, at Goulburn.

DR. H. P. WELCHMAN is acting as locum tenens for Dr. Metcalf, at Norfolk Island, during the latter's absence in Europe.

NEW ZEALAND.

THE Council of the New Zealand Medical Association have submitted to the Government for consideration a Bill to repeal the Medical Practitioners Act of 1869. The new measure contains a number of very stringent provisions, the object of which is to conserve the interests and privileges of the profession, and to put down quackery with the strong arm of the law. The Bill has not yet been fully considered by the Government, but there are grounds for believing that it will be introduced by the Colonial Secretary.

IN the Supreme Court, Wellington, on July 9, the case *Barnes v. Drs. Gillon and Johnston*, was heard. The claim was for £800 as damages for wrongful treatment of plaintiff by defendants while in their charge in the Wellington Hospital, in 1879. After hearing evidence, Mr. Justice Richmond decided there was no evidence to go to a jury, and the plaintiff was nonsuited.

IN the Auckland Supreme Court, on June 22 and 23, Ada Freestone brought an action against Dr. T. B. Kenderdine, of Auckland, to recover £400 damages for the loss of an eye through alleged negligent treatment. In August last year, plaintiff caught cold in her left eye, and she consulted the defendant, who prescribed a cantharides blister, which, it is stated, he told her to put over her eye, and he also gave a prescription for a lotion. Plaintiff having obtained the blister, placed it directly over her eye, and let it remain for nearly five hours, when, being unable to bear the pain, she removed it. The eye was then almost a mass of jelly, the sight being, of course, entirely gone. About six weeks afterwards she again visited Dr. Kenderdine, who said he had not told her to open her eye and put the blister into it, and on his advice she saw Dr. Purchase, who removed the eye. For the defence, it was contended that Dr. Kenderdine told the plaintiff to place the blister on her temple, as no man in his senses would tell a patient to apply anything so powerful directly to the eye, and that his instructions were misunderstood. The jury, after a quarter of an hour's deliberation, brought in a verdict, finding for the defendant. His Honor Mr. Justice Gillies gave judgment accordingly, with costs against the plaintiff.

WE are pleased to learn that Dr. James Galbraith, of

Invercargill, who, as we reported in our last issue, was shot at and severely wounded in the thigh by the local Inspector of Nuisances, is progressing favourably. Up to the end of last month, some thirty pellets of No. 3 shot had been extracted from his leg, and there still remained several deeply imbedded in the flesh. It is stated that the charge contained at least 100 pellets.

WE very much regret to learn that Dr. Samuel Thorpe, a very old and respected practitioner, disappeared from Westport on Friday evening, the 6th July, and there is too much ground for fear that he accidentally fell into the River Buller during a heavy storm. The last that was seen of him was on the wharf about 6.30. His hat was picked up near the spot on Saturday, July 7. He leaves a large family.

A NUMBER of Dr. J. Carnegie Macmullen's friends entertained that gentleman at dinner at the Northern Club, Auckland, on Saturday evening, July 7, prior to his departure for Australia. Dr. Macmullen has gone to Melbourne, where, we understand, it is his intention to practise his profession. During his residence in Auckland, Dr. Macmullen made many friends, and gained the esteem of the general public.

DR. A. G. H. BUCKBY, late of the Mercury Bay District Hospital and formerly of Patea, has settled at Brunnerton, in a coal-mining district, seven miles N.E. of Greymouth.

DR. H. HOWARD, late of Wairoa, is now in charge of the Mercury Bay District Hospital, on the east coast of the Coromandel peninsula.

DR. J. W. KEYWORTH, late of Nelson and formerly of Napier, has been appointed Medical Officer of the Wairoa District Hospital, 54 miles N.E. of Napier.

DR. JAS. MACPHERSON, formerly of Invercargill, has commenced practice at Dunedin, in conjunction with Dr. Martin.

QUEENSLAND.

THE Lady Bowen Hospital and ground, in Ann Street, Brisbane, has been sold for £10,000.

ON July 21, a painful and somewhat serious accident occurred to Dr. E. H. O'Doherty, of Brisbane. He had been attending a patient who lives in Petrie-terrace, and was about to remount his horse, but as soon as he had put his foot in the stirrup the animal became restive, began backing and rearing and galloped down the street. Dr. O'Doherty had no chance of gaining the saddle and in a few moments the horse threw him to the ground. He was picked up in an unconscious condition, and conveyed to his residence, where he was immediately attended to. Consciousness was soon restored, but it was found that he had sustained a severe blow on the back of the head, which had not, however, fractured the skull. His ankle also was badly sprained and his elbow severely bruised. Dr. O'Doherty is now progressing very favourably, and it is expected that with the exception of the sprained ankle he will soon be all right.

DRS. G. DE VEUILLE BELSON and R. T. W. THOMSON, new arrivals, have commenced practice at Townsville.

DR. J. BOOTH has resigned his appointment as Government Medical Officer at Thornborough.

DR. G. E. BLANCHARD, formerly of Portobello, Midlothian (Scotland), has commenced practice at Thornborough, the centre of the Hodgkinson Gold Fields, 1,100 miles N.W. of Brisbane.

DR. A. CUTFIELD, of Mackay, has returned to the

colony by the B. I. S. N. Co.'s steamer, "Taroba," after an absence of nine months in England.

DR. MURDOCH MACKENZIE, late Deputy Medical Superintendent of the Beechworth Lunatic Asylum (Vic.), has settled at Cairns, a seaport on Trinity Bay, 1,020 miles N.W. of Brisbane.

SOUTH AUSTRALIA.

WITH regard to the registration of an American diploma in South Australia, referred to in our last issue, we understand that all the correspondence relating to the subject has been forwarded to the Attorney-General for his perusal. The Medical Board has declined to register the diploma, as the Board is of opinion that Mr. Bollen's qualifications would not entitle him to hold a State medical appointment under the Federal Government of the United States of America.

THE Council for the next Intercolonial Medical Congress of Australasia, to be held in Melbourne, in January, 1889, have elected the following practitioners of Adelaide to the offices mentioned:—Vice-Presidents of the Congress, Dr. E. C. Stirling and Dr. J. C. Verco. Sections—*Medicine*, Vice-President, Dr. J. Davies Thomas; *Surgery*, President, Dr. E. C. Stirling; *Anatomy and Physiology*, Vice-President, Professor A. Watson; *Obstetrics and Gynaecology*, Vice-President, Dr. E. W. Way; *Diseases of the Eye, Ear, and Throat*, President, Dr. M. J. Symons; *Psychological Medicine*, Vice-President, Dr. A. S. Paterson. The Secretary for South Australia is Dr. B. Poulton, North Terrace, Adelaide.

ARRANGEMENTS have been made in Adelaide for the formation of ambulance classes, under Dr. Hamilton amongst the police, under Dr. Poulton amongst the railway employés, and Drs. Dawes and Popham have large classes arranged at Gawler. Two classes under Dr. Bickle recently completed their courses at Mount Barker, as also a class at Woodville, instructed by Dr. Mitchell. A ladies' class at North Adelaide, instructed by Dr. Cockburn, was also examined last month.

THERE are 28 branches of St. John's Ambulance Association in South Australia. The certificates already issued number no less than 379.

DR. W. W. EWBANK, a new arrival, has commenced practice at College Town, a suburb of Adelaide.

DR. A. H. GAULT, late House Surgeon of the District Infirmary, Ashton-under-Lyne (Eng.), and formerly House Surgeon of the Manchester Royal Infirmary, has commenced practice at Mitcham, a suburb, 4½ miles from Adelaide.

TASMANIA.

DRS. E. O. GIBLIN and E. J. CROUCH, of Hobart, have been appointed members of the Tasmanian Board of Medical Examiners, in the room of Drs. J. W. Agnew and H. A. Perkins, resigned.

DR. M. HERDEGEN, late of Albury (N.S.W.), has commenced practice at Deloraine, on the River Meander, 156 miles N.W. of Hobart.

VICTORIA.

DR. DICK, the Superintendent of Charitable Institutions, has made a tour of inspection of the Castlemaine district, with a view to selecting a site suitable for a lunatic asylum. Various places were visited, and eventually Dr. Dick expressed his opinion that the Park Reserve was admirably suited for the purpose specified. Dr. Dick will visit other centres prior to submitting his report to the authorities.

A SERIOUS outbreak of measles has occurred at Penshurst, in the western district. At the beginning of this month 46 cases were known to exist in the district.

AT an examination of the Flinders-street Railway Ambulance Class, recently held in Melbourne by Dr. H. C. Bowser, sixteen students presented themselves, ten of whom passed, two with special credit, and one with credit.

WE very much regret to learn that Baron Sir Ferd. von Mueller, K.C.M.G., M.D., F.R.S., was thrown from a tramcar on July 31. He was suffering considerable shock, and received some wounds about the head and face; however, he is now progressing favorably, and hopes to resume his official duties in a week or two.

AT the St. Kilda Police Court, near Melbourne, on July 13, a dairyman named J. W. Garritt, was fined £5, with £3 ss. costs, for having sold milk which was found to contain from 9 to 12 per cent. of added water, and to be deficient in butter fat 23 per cent.

DR. A. E. BYRN, late of Hughenden (Qu.), and formerly of Maldon (Vic.), has settled at Casterton, on the Glenelg River, 267 miles W. of Melbourne.

DR. W. H. CUTTS, JUN., late of West Melbourne, has commenced practice at Oakleigh, 10 miles S.E. of Melbourne.

DR. G. R. EAKINS, of Echuca, has been appointed a Surgeon, on probation, in the Victorian Mounted Rifles, with the relative rank of Captain.

DR. A. V. HENDERSON has removed from Lilydale to Camberwell, a suburb five miles E. of Melbourne.

DR. GEORGE HORNE, of North Fitzroy, has been appointed to the command of the Victorian Volunteer Ambulance Corps.

DR. P. H. MACGILLIVRAY, of Sandhurst, has been unanimously chosen as President of the Bendigo School of Mines.

DR. J. McCONNOCHIE, formerly of Ballarat, has settled at Seymour, on the Goulburn river, 62 miles N. of Melbourne.

DR. J. W. MARTIN, a new arrival, has commenced practice at Albert Park, South Melbourne.

DRS. PINNOCK AND OCHILTREE have been elected Honorary Medical Officers of the Ballarat Hospital after a keen contest.

DR. C. J. RUTLEDGE has settled at Trentham, 64 miles N.W. of Melbourne.

DR. DUNCAN TURNER, of Melbourne, has been appointed President of the Dental Board of Victoria.

DRS. J. C. WIGHT AND C. H. MOLLISON, formerly Resident Medical Officers at the Melbourne Hospital, have commenced practice in William Street, Balacava, a fashionable suburb of Melbourne.

WE have been requested to state that Mr. F. G. Collins, of Melbourne, has been appointed representative in Australasia of the Apollinaris Company, London, sole exporters of the Apollinaris, Hunyadi János, and Friedrichshall Natural Mineral Waters.

HOSPITAL INTELLIGENCE.

AT a meeting of the Board of Directors of the Prince Alfred Hospital, Sydney, held on July 12, a letter was received from the Medical Superintendent (Dr. James Graham) tendering the resignation of his appointment in consequence of his early departure for Europe. Dr. Graham's resignation was accepted with

regret, and, on the motion of Sir Alfred Roberts, the following resolution was unanimously adopted:—"That in accepting the resignation of Dr. Graham, the Board desires to express its sense of the earnest manner in which he has at all times devoted his marked ability to the arduous and responsible work of his office as Medical Superintendent. The Board much regret the necessity for Dr. Graham's departure and beg him to accept their best wishes for a prosperous voyage and pleasant tour." At the same meeting Sir Alfred Roberts reported that the hospital was solely indebted to Professor Threlfal for the good construction and efficiency of the new large galvanic battery, and that he spared no pains in advising the Honorary Secretary upon all the details, consequently the Board instructed the latter officer to express its deep obligation to the professor for the great interest and trouble he has taken in the construction of the battery, and to tender him their earnest thanks for the same. It was also resolved,—"That the warmest thanks of the Board are also due to Professor Threlfal for the study and labor he has bestowed upon the development and construction of the large, perfect and delicate galvanometer he has designed and has had made at the University under his constant supervision, for the purpose of measuring the galvanic current with precision." Copy of the foregoing to be sent to Professor Threlfal. It was also decided that the offices of those members of the Honorary Medical Staff who were elected on the 8th August, 1882, be advertised as vacant, together with an announcement that the physicians and surgeons who filled them are eligible for re-election for another term of six years, and that the election of the additional Honorary Officers take place at the same time. A special meeting of the conjoint Board to be held on August 9, 1888.

THE funds of the Albury (N.S.W.) Hospital are in such an unsatisfactory condition that the Committee have decided, for the present, to admit no more patients.

AT the Brisbane Hospital for Sick Children, 303 cases were treated during the 12 months ended June 30; 188 were discharged cured, 86 were discharged relieved, and 12 incurable, while 18 had died and 4 had been removed; leaving a total of 45 cases now in hospital. The receipts for the year have been £4,282 16s. 5d. and the expenditure £2,585 10s. 2d.

THE Committee of the Melbourne Hospital intend to establish an observation ward in connection with the institution, and also to appoint a Deputy Medical Superintendent.

THE annual report of the Alfred Hospital, Melbourne, for the 12 months ended June 30, shows that the number of patients treated in the hospital was 4,501, made up by 1,494 in-patients, 2,385 out-patients, and 622 casualties. This number was the largest treated since the foundation of the hospital. The typhoid fever camp was again largely availed of by the various municipalities during the recent outbreak of the fever, 62 patients having been sent to the camp. The usefulness of the Nurses' Training School is becoming more and more marked every year, and its popularity is increasing. There are 23 pupils on the roll, 12 of whom do not reside at the hospital, but contribute to their tuition, and 11 live in the institution, and give their services in return for the knowledge imparted to them. During the year 13 pupils passed their preliminary examination, and eight have obtained the hospital's "Certificate of Competency." A Clinical School for the instruction and experience of medical students was opened in March last, and there are now 14 students attending the classes. Eight of the students are males, and six

females, but they all receive their instructions simultaneously, and, so far, the system has been found to work exceedingly well. The school is formally recognised by the Council of the University, which has voted it a grant in aid for the present year of £100. The pay wards continue to be largely used, no fewer than 156 patients having been registered during the year. Of these 126 were discharged cured or relieved, 23 died, and 7 still remain in the institution. The receipts, including £5,000 from the Government, have been £15,124 1s. 6d., and the expenditure £14,698 8s. 2d., leaving a credit balance of £425 13s. 3d.

AT an examination of nurses in training at the Alfred Hospital, Melbourne, held during the first week in August, 17 candidates presented themselves. Of this number eight passed the final examination and seven the preliminary examination.

AT a recent meeting of the Committee of the Melbourne Womens' Hospital, the report of the Subcommittee on the question of students' fees was read, affirming the expediency of giving half the fees in the midwifery department to the hospital, and half to the Honorary Medical Staff, and two-thirds of the infirmary fees to the hospital, and one-third to the Honorary Medical Staff. Major Goldstein said that the students were merely required to attend 20 midwifery cases in the institution. The Resident Medical Officers conducted the cases, and he could not see that the Honorary Staff had any right to the fees at all. The fees ought to go to the hospital, which allowed the students to comply with the requirements of the University. Dr. Jamieson said that though the Honorary Medical Staff were under no obligation to give instructions to the students, still the question was, should they not be encouraged to do so by the hospital. However, finally, the motion for the adoption of the report was negatived, and the matter in dispute was left over for discussion at the annual meeting, which will be held on August 15.

THE Committee of the Melbourne Women's Hospital have agreed to the proposition that it should be optional with nurses on entering the institution to say whether they would serve for twelve months paying a fee of £1 1s., or for six months paying a fee of £12 12s. The time of probation for both classes to be extended to one month.

AT a special general meeting of subscribers to the Victorian Eye and Ear Hospital, held in Melbourne on July 13, Dr. J. P. Ryan was appointed third Honorary Surgeon to the institution, and Dr. Barrett, Assistant Honorary Surgeon.

AT the Victorian Eye and Ear Hospital during the twelve months ended June 30, the total number of attendances was 17,132, of whom 2,989 were new cases, and of these 406 were admitted as in-patients; whilst the number of operations performed was 728.

THE annual report of the Committee of the Austin Hospital for Incurables at Heidelberg, near Melbourne, shows that during the twelve months ending June 30, there had been 49 admissions, viz., 28 men and 21 women; of this number 21 were cancer cases. The deaths for the same period numbered 30, of which 16 were cancer cases, whilst 12 patients left to go to their friends. On the 30th June there were 74 patients in the hospital, viz., 41 men, 30 women, and 3 children. The general wards had been kept constantly filled throughout the year, and numerous urgent applications had to stand over for want of accommodation. At present there are 10 applicants waiting for vacant beds in general wards alone. The total receipts for the year

amounted to £6,168 7s. 2d. The total expenditure was £2,821 12s. 6d.

THE annual report of the Board of Management of the Melbourne Homœopathic Hospital for the year ended June 30, shows that the total number of persons treated during the twelve months was greater than in any preceding year, numbering 2,522, which included 567 in-door patients and 1,955 out-door patients, 938 of which were males and 1,584 females. The total number of prescriptions dispensed was 11,316, being 2,062 more than the year before. The record showed that of the in-patients, 450 were discharged as cured, 22 discharged incurable, 51 died, and 44 remained in the hospital. The receipts in connection with the maintenance fund for the year, including the overdraft at the bank, came to £2,986 12s. 7d., and the expenditure amounted to £2,829 12s. 2d.

OBITUARY.

JAMES DUNLOP DUNLOP.

WE very much regret to have to record the death of Mr. James Dunlop Dunlop, M.B. et Ch.M. Edin., 1881, L.R.C.P. et R.C.S. Edin., 1881, who died at his residence at Glenelg, S.A., on July 4. His death was not unexpected as he was suffering severely from serious illness for some time, though he had been able to carry on the practice of his profession until the day of his death, when he developed symptoms of uræmia, which terminated fatally the same night. Drs. Way, Finnis, and Henry were in close attendance up to the last. Although only in Glenelg a little over a year, Dr. Dunlop secured the confidence of the residents to a marked degree, and his loss will be acutely felt by a large circle of patients and friends. Dr. Dunlop's abilities were of no ordinary character. His career at the University of Edinburgh was marked by great success. Latterly, during a long residence at the Adelaide Hospital, as Medical Superintendent of the institution, he displayed unusual adaptability to the profession he had adopted, and was, moreover, not only appreciated as a physician by his brethren, but always secured the respect and esteem of his patients.

WILLIAM ROBERT CLAVEY.

MR. WILLIAM ROBERT CLAVEY, L.S.A. LOND., 1832, an old colonist of 26 years standing, died at his residence, 31 Dorcas Street, South Melbourne, on July 5, at the ripe age of 77 years; the deceased gentleman, prior to his departure for Australia, practised at Bath, in England.

JOHN WILLIAM SMITH COWARD.

MR. J. W. S. COWARD, L.S.A. Lond., 1838, J.P., died at his residence, 287 Cashel Street, Christchurch, N.Z., on July 8, aged 73 years. The deceased gentleman was a native of Canada, where he was born in 1815, and was the son of an officer in the English army. He arrived in Canterbury in 1857, and held for many years the position of Coroner, and also that of Medical Officer to the gaol, lunatic asylum, and police in Christchurch.

ROBERT GRAHAM JOHNSTON.

ROBERT GRAHAM JOHNSTON, L.R.C.S. Irel., 1872, L.R.O.P. Edin., 1873, a well-known medical practitioner at Waimea (Prov. Nelson), was killed in June, by being thrown from his horse; it seems that the doctor had started to ride from Brightwater to Tadmor, where his professional services were required. That same night

the doctor's horse returned home alone, and a search which was immediately made did not discover what had become of the rider. The next morning, however, a drayman reported having found the dead body of a man in Norris Gully, which proved to be that of the unfortunate gentleman. From the appearance of the body it was evident that the deceased had been thrown by the horse, and, his foot catching in the stirrup, he had been dragged for some distance over the rough, pebbly road, death overtaking him before his foot was freed. Dr. Johnston had been a resident in the Waimea district for some years.

WILLIAM JOHNSTON.

MR. WILLIAM JOHNSTON, Ch.M. Glas., 1835, died at his residence, Branhholme, Victoria, on June 30, aged 73 years. The deceased gentleman arrived in Victoria early in 1863, when he commenced practice at Horsham. He afterwards removed to Branhholme, where he spent the last few years in retirement. Prior to his departure for Australia he practised at Belfast, Ireland.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Atwater, Edward Paul, M.D. Univ. Penn., Phila., U.S.A., 1888.

QUEENSLAND.

McDonogh, Augustus William, L.S.A. Lond., 1872.
Mackenzie, Murdoch, L. et L. Mid. R.C.P. et R.C.S. Edin., 1885; L.F.P.S. Glas., 1885.
Blanchard, George Easingwood, L.R.C.P. et R.C.S. Edin., 1887; L.F.P.S. Glas., 1887.
Belson, George de Veuille, M.A. Oxon., L.R.C.P. Lond., 1887; M.R.C.S. Eng., 1887.
Thomson, Robert Thomas Walter, M.B. et Ch.M. Glas., 1876.

SOUTH AUSTRALIA.

Bollen, Christopher, M.B.
Gault, Arthur Henry, L.R.C.P. Lond. et M.R.C.S. Eng., 1886.
Potts, Walter Alfred Beavor, M.R.O.S. Eng. et L.S.A. Lond., 1882.
Kwbank, William Withers, M.R.C.S. Eng. et L.S.A. Lond.

TASMANIA.

Herdegen, Moritz, M.D. Munic., 1881; State's Exam., 1880.

VICTORIA.

Parkinson, Charles Joseph, L.S.A. Lond., 1882; M.R.C.S. Eng., 1882; M.B. Lond., 1884.
Jermaine-Lulham, Frederic Sidney, M.R.C.S. Eng., 1888; L.R.C.P. Lond., 1888.
Martin, John Wilson, L.R.C.P. et R.C.S. Edin., 1887; L.F.P.S. Glas., 1887.
Byrn, Archdall Edward, L.R.C.P. Edin., 1864; L.F.P.S. Glas., 1864.

MEDICAL APPOINTMENTS.

Amess, James, M.B. et Ch.B. Melb., to be Public Vaccinator at Wilby, Vic.
Bollen, Christopher, M.B., to be a Public Vaccinator in South Australia.
Browne, David Graham, M.D. et Ch.M. Qu. Univ. Irel., to be a Surgeon in the Queensland Defence Force.
Clatworthy, Herbert, M.R.C.S.E., to be a Surgeon in the Queensland Marine Defence Force.
Gault, Arthur Henry, M.R.C.S. Eng., L.R.C.P. Lond., to be Public Vaccinator and Medical Officer to attend to the destitute poor and aborigines within the district of Mitcham, S.A.
Harbison, John Wesley, M.B. et Ch.B. Melb., to be Health Officer for shire of Numurkah, Vic.
Kavanagh, Edmund Raphael, L.R.C.P. et R.C.S. Edin., L.F.P.S. Glas., to be Government Medical Officer and Vaccinator for the district of Junee, N.S.W.
Keyworth, John White, M.D. Lond., M.R.C.S.E., to be a Public Vaccinator for the district of Wairoa, N.Z.

Knight, Alfred Osborne, M.R.C.S.E., elected Honorary Surgeon of the Auckland Provincial Hospital, N.Z., vice Dr. J. Carnegie MacMullen, resigned.
McAdam, Robert Louis, M.D., M.B. et Ch.B. Dubl., to be Health Officer for the Lower Murray Riding, also Public Vaccinator at Swan Hill, Vic., vice C. W. Pardey, M.B., who has left the district.
McConnochie, James, M.D., to be Health Officer for shire of Goulburn, Vic., vice W. J. R. Ray, M.R.C.S., resigned.
Nelly, John Francis, L.R.C.P. et R.C.S. Ed., L.F.P.S. Glas., elected Resident Surgeon at St. Vincent's Hospital, Sydney, vice Dr. A. J. O'Flannagan, resigned.
Owens, Edward Matthews, M.R.C.S.E., L.R.C.P. Ed., to be a member of the Queensland Medical Board, in the room of Dr. W. Hobbs, retired.
Perry, Lloyd Davenport, L.R.C.S. Edin., to be Government Medical Officer and Vaccinator for the district of Emmaville, N.S.W.
Potts, Walter Alfred Beavor, M.R.C.S. Eng., to be Public Vaccinator and Medical Officer to attend the destitute poor within the district of Border Town, S.A.
Rankin, Richard Power, L.R.C.P. et R.C.S. Edin., to be Government Medical Officer and Vaccinator for the district of Walgett, N.S.W.
Rutledge, Charles James, L.R.C.S. Irel., to be Public Vaccinator at Trentham, Vic., vice Dr. T. H. Hutchinson, resigned.
Scott, Henry James Herbert, L.R.C.P. Lond., M.R.C.S. Eng., to be Government Medical Officer and Vaccinator for the district of Tuena, N.S.W.
Smith, Alfred Frederic, L.R.C.S. Irel., L.K.Q.C.P. Irel., to be Public Vaccinator at Crystal Brook, S.A.
Weekes, Charles Jones, L.R.C.P. Lond., M.R.C.S.E., to be Assistant Medical Officer at the Coast Hospital, near Sydney, vice Dr. R. W. Young, resigned.

BIRTHS, MARRIAGES, AND DEATHS.

. The charge for inserting announcements of Births, Marriages, and Deaths is 2s. 6d., which should be forwarded in stamps with the announcement.

BIRTHS.

BOWKER.—July 29, at Darling Point, Sydney, the wife of R. Steer Bowker, M.R.C.S. Eng., L.R.C.P. Ed., of a son.
ELLISON.—On the 1st July, at North Terrace, Adelaide, the wife of S. K. Ellison, M.R.C.S.E., of a daughter.
GARDE.—On the 23rd July, at Maryborough, Queensland, the wife of H. C. Garde, F.R.C.S., of a daughter.
PHILIP.—July 19, at Crown Street, Surry Hills, Sydney, the wife of Dr. Alexander Philip, of a son.
RORKE.—July 12, 1888, at St. Leonards, near Sydney, the wife of Dr. Charles Rorke, of a son.
SCOT-SKIRVING.—July 18, at Elizabeth-street, Hyde Park, Sydney, the wife of R. Scot-Skirving, M.B. of a son.
TENNANT.—July 11, at Tenterfield, N. S. Wales, the wife of T. H. Tennant, M.D., of a son.

MARRIAGES.

EWING—SWINSON.—July 28, at Bowral, N. S. Wales, by the Rev. J. W. Debenham, M.A., John, third son of the Rev. J. O. Ewing, of St. Michael's, Wollongong, to Beatrice Maude, fourth daughter of George Newton Swinson, M.R.C.S. Eng., L.R.C.P. Ed., Bowral.
HILL—ROBJOHNS.—On the 13th July, at North Adelaide, by the Rev. J. O. Hill, Alfred W. Hill, M.D. Brus., L.R.O.P. Lond., M.R.C.S. Eng., to Kate Alexandra, the only daughter of W. A. Robjohns, of Newnham-on-Severn, Gloucestershire, England.
HOBBS—CORTIS.—July 25, 1888, at Leichhardt, Sydney, by the Rev. Thos. Holmes, Oliver Hobbs, of Cootamundra, to Alice Weddell, youngest daughter of William S. Cortis, M.D., Annandale, Sydney.
KELTY—WHITNEY.—July 4, by the Rev. Canon Read, William Keltly, M.B., O.M., of Carcoar, N.S.W., to Isabella Rachel, eldest daughter of W. F. Whitney, Coomberg Park, Carcoar.
PARKE—LAMBERT.—August 1, at Berrima, by the Rev. George Sheppard, B.A., John Arthur, second son of the late Samuel Parke, formerly of Wollongong, to Laura, third daughter of George Prowd Lambert, M.R.C.S.E., of Berrima.
STANTON—O'CONNOR.—On the 25th July, at Richmond, Melbourne, by the Rev. J. Kennedy, S.J., Thomas Stanton, M.B. (S.C.D.), to Kate, third daughter of Nicholas O'Connor, Richmond.

DEATHS.

ELAM.—On June 25, at his residence, Tamaki West, Auckland, N.Z., John Edward Elam, M.D., formerly of Leeds, Yorkshire, aged 65 years.
EMBLING.—On the 25th July, at Hawthorn, Melbourne, Lettie, wife of Dr. Herbert A. Emling, Melbourne, aged 23 years.

REPORTED MORTALITY FOR THE MONTH OF JUNE, 1888.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Cancer.	Child-bearing.
N. S. WALES.														
Sydney	132,846	312	179	62	5	2	3	1	3	5	17	14	4	3
Suburbs	215,849	789	288	129	5	8	18	...	12	6	33	21	6	4
NEW ZEALAND.														
Auckland	35,965	83	32	7	...	...	1	...	1	...	3	2	1	...
Christchurch...	16,217	40	8	2	...	...	...	...	...	...	1	1	...	...
Dunedin	24,334	43	21	2	...	...	1	...	1	...	4	1	1	...
Wellington	28,235	77	28	9	...	...	4	2	...	...	2	1	2	...
QUEENSLAND.														
Brisbane	51,689	200	67	32	}	1	18	...	2	6	10	1	4	6
Suburbs	21,960	136	40	28										
SOUTH AUSTRALIA														
Adelaide	316,087	913	290	87	...	...	13	...	8	9	40	31	4	3
Adelaide	43,527	113	67	17	...	...	2	...	2	...	12	7	2	...
TASMANIA.														
Hobart	32,108	88	53	10	...	...	...	...	2	...	4	5	1	1
Launceston	20,145	80	34	5	...	...	2	...	2	2	1	6	1	...
Country Districts.....	88,774	281	95	...	...	...	4	...	1	4	...	...	...	...
VICTORIA.														
Melbourne	69,774	195	85	215	1	3	32	...	20	6	85	58	22	16
Suburbs	275,606	1,182	545											

METEOROLOGICAL OBSERVATIONS FOR JUNE, 1888.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.			Depth.	Days.		
							Inches			
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E. ....	...	68.2	55.3	39.3	30.005	...	...	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.	118	63	52.1	37	...	...	4.130	20	78	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.	128	80.4	59.4	39.4	30.201	...	0.311	7	65	s.
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.	115	64.8	45.3	25.4	...	...	0.650	6	72	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.	94	58	44.4	33	...	...	0.970	13	77	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E. ....	...	62.2	48.9	34	29.848	...	3.05	18	88	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E. ....	...	62	48.2	30	29.945	...	4.05	14	83	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E. ....	...	66.9	52	36.2	29.999	...	1.19	13	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E. ....	...	72.4	55.7	41.9	30.158	...	1.06	12	71	w.
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.	120	62	50.1	36.3	...	...	2.384	20	80	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

MULTIPLE FIBROID OF THE UTERUS REMOVED BY ABDOMINAL HYS- TERECTOMY.

READ BEFORE THE MEDICAL SECTION OF THE ROYAL
SOCIETY OF NEW SOUTH WALES.

By RALPH WORRALL, M.D., M.Ch., Hon.
ASSISTANT-SURGEON TO THE DEPARTMENT
FOR THE DISEASES OF WOMEN AT THE
SYDNEY HOSPITAL.

E. H. (æt. 46, married 15 years, no child, nor miscarriage) has been suffering for the past four years from severe pain in the lower abdomen and back, and a constant "bloody, mattery discharge," increased to a flooding every three weeks.

Her appearance is that of one who has suffered much—pulse 120 weak, heart, lungs and kidneys normal, slight œdema of the legs.

She has been told by several surgeons that she has a tumour of the womb, and has taken much medicine without any relief to her sufferings. Local examination disclosed a tumour immovably wedged in the pelvis, posterior to the uterus, which was drawn up behind pubes, and had a cavity measuring $8\frac{1}{4}$ inches. Three other tumours occupied the lower abdomen. These were fairly moveable.

My colleagues concurred in the propriety of operation, and the risk having been fully explained to the patient, in the presence of Drs. Sydney Jones and Kyngdon, she decided to accept it.

August 2.—Methylene was administered. On making the usual incision in the middle line, some ascitic fluid flowed out. The size of the tumours necessitated prolonging the incision two inches above the umbilicus before they could be delivered. Tait's corkscrew was used, but caused severe hæmorrhage.

There were no adhesions, but the bladder had to be carefully dissected off the anterior uterine wall before the wire of the *serre noeud* could be applied. This dissection caused free bleeding, necessitating the application of a temporary wire rope, above which the pins were introduced, and the uterus with its tumours cut away. The bladder wall was so thin that the sound in the bladder could be seen shining through. The anterior portion of the capsule which had been dissected off with the bladder was stitched to the parietal peritoneum in the lower angle of the wound. The wire of the *serre noeud* was made to embrace the remainder, and to include in its circle the

appendages. A small fibroid growing from the cervix about the level of the external os was left, and the wound was closed with silk sutures. The operation lasted about one hour and a half, and was well borne by the patient, the pulse immediately after being 70.

In about four hours (owing no doubt to the shrinking of the pedicle) considerable hæmorrhage was noticed, and I was sent for. I found the pulse very weak and rapid, and the dressings soaked through with blood. A few turns of the screw, and the careful application of perchloride of iron to the stump, effectually checked all bleeding, and it did not recur; but from that hour the patient went down hill rapidly. Although there was no vomiting, nor failure of the kidneys (about four ounces of urine were drawn off every four hours), and the temperature remained comparatively low, reaching its highest point (101·2) on the afternoon of the second day, yet the pulse became weaker and more rapid, there was considerable abdominal pain and distension, and she gradually sank, death taking place just thirty hours after the operation.

Post mortem, made fourteen hours after death by Dr. Henry, house physician, showed that the abdominal wound had united by first intention, and that the flaps of parietal peritoneum were glued together. The stump was firmly embraced in the lower angle of the wound, but had not yet become united to the parietal peritoneum, except where this had been stitched to that part of the capsule which had been dissected off with the bladder. This viscus was uninjured. There was no blood to be seen, but the pelvis contained about a cupful of pus, and the intestines were patched with numerous areas of intense congestion. I am at a loss to account for this rapid formation of pus. Dr. Wilkinson, to whom I mentioned the matter, suggested injury of the ureters as the most likely cause. They were certainly not injured in neighbourhood of the bladder; but as it is just possible that one of them received damage during the raising and delivery of the tumours, I regret I did not remove the kidneys and explore the ureters throughout their whole extent. The *post mortem* was made without consent, and therefore was not so complete as I could have wished.

Examination of the uterus and tumours showed that there were nine distinct outgrowths, weighing in all three and a-half pounds.

This case is my seventh abdominal section, and first death, since being connected with the Sydney Hospital, and has naturally been a matter of much concern to me; yet, if I had it

all to go over again, I know of nothing which I should desire to alter, my only regret being that the House Surgeon on duty did not act on his own responsibility when the hæmorrhage occurred, without waiting for my arrival. More than half a pint of blood must have been lost, and every operator knows that hæmorrhage means increased liability to septicæmia. It is a satisfaction to think that the patient sought the operation, and was in no way persuaded thereto. Electricity could have exerted no influence on these great outgrowths, and there was, therefore, no alternative for the patient but to endure her helplessness and suffering, or to accept the risk of operation; as that suffering was constant and extreme, who can wonder if she chose the latter?

I am indebted to my colleagues, Dr. Chambers and Dr. Sydney Jones, for assistance during the operation.

ETHICS IN THE ADMINISTRATION OF ANÆSTHETICS.

READ BEFORE THE N. S. WALES BRANCH, B.M.A.

By SAMUEL T. KNAGGS, M.D., F.R.C.S.I.

THE importance of the question which I introduce for discussion to-night is emphasized by the fact that during the years 1885, 1886, and 1887, no less than nine deaths occurred in this colony during the administration of anæsthetics for surgical operations. These deaths have attracted much attention from the public, and within the last month they formed a subject for inquiry by Parliament, and I now hold in my hand a printed return, which was ordered to be made by our Legislative Assembly, giving particulars regarding these deaths.

This subject involves questions of vital importance, not only to the members of this Branch, but the profession in general, and I trust no apology will be necessary from me in attempting to elicit the views of those present as to the recognition of a code of ethics to be adopted regarding the administration of anæsthetics, such as would ensure a careful selection of the anæsthetic to be used, an exhaustive examination of the patient before, and supervision during its use, as well as a necessary protection to the administrator and surgical operator in case of fatal result.

The term "Ethics" I use advisedly, and with the meaning attached to it which comprises "that part of moral philosophy which treats of Human duties, their grounds and obligations." Therefore, ethics in the administration of anæsthetics should involve an inquiry into the duties due by the administrator of the anæsthetic to his patient—his colleague the operator, and himself—and rules involving the safety of them all.

Let me give an example of the untoward results due to hastily undertaking the administration of an anæsthetic. Some years ago when I had somewhat less knowledge of the responsibilities of an anæsthetist than I now have—I had but just commenced the practice of my profession—I was requested by a senior, and very much respected, surgeon (since deceased) to assist him at an operation by administering the anæsthetic. On my arrival at the operating room I found the patient already on the table. A cursory examination of the case disclosed it to be one of abdominal tumour in a female aged 26 years. The tumour occupied a position in the right hypochondriac region, was about the size and shape of a full-grown foetal head, and was very moveable. Upon my asking the probable nature of the tumour and its attachments, I was informed that these details would be disclosed in due course as the operation proceeded. I then pertinently—but, probably impertinently—asked if the operator really purposed "removing he didn't know what from he didn't know where?" and was met by the peremptory retort, that he being the operator, that was his concern—my business was to give the anæsthetic! The nature of the tumour and its attachments did become disclosed as the operation progressed. It proved to be a sarcomatous offshoot from the liver, which could not be removed, and the operation led to a disastrous and fatal result in ten days. Much odium was attached to all concerned in the operation, and I, as one taking an active part in it, had to bear my full share.

Since then I have had my mind directed to this question as to the responsibility incurred by those physicians and surgeons who may be present at operations, actively or passively, as operators, assistants, chloroformists, or spectators. I think the ethics of this question of such importance as to demand a full and free discussion, especially in these times, when a certain section of the public appear to be upon the alert to establish grounds—sufficient or otherwise, upon which to found a legal action for malpractice—and, as it were, extort blackmail from any member of our profession who may inadvertently give cause for such an attempted swindle.

Judging from opinions expressed by some surgeons, I think there is a mistaken impression held by many members of the profession that there is an inequality in the nature of the responsibility relatively incurred by the operator and the administrator of the anæsthetic—whereas I am inclined to assume that each party is equally responsible for any mishap due to the anæsthetic—or more correctly, any fatality the immediate result of the operation—and I must confess that I cannot see how the responsibility

can be differentiated. At an inquest where the subject died while under the influence of an anæsthetic, I heard the operating surgeon, who had charge of the case, say to the Coroner—"I did not examine the patient's heart; that is not my business. I leave those details to the chloroformist; I have nothing to do with the anæsthetic, and do not consider myself responsible for the result of giving the anæsthetic."

I cannot do better in combating this dictum than quote Dr. Frederick Hewitt,* administrator of anæsthetics at Charing Cross Hospital, and Instructor in anæsthetics at the London Hospital, upon this question:—

"It will not now suffice to place a stethoscope momentarily over the cardiac area, produce a small bottle and a piece of lint from the pocket, and indiscriminately proceed to 'give a whiff of chloroform' to every case that may be entrusted to our care. In order that a pleasant, safe, and efficient narcosis may be produced—and such are the requirements of our times—it is necessary to pay attention to many points, theoretical as well as practical; the nature and length of the operation must be considered; the idiosyncracies and general condition of the patient must be investigated; the dangerous symptoms which are most likely to arise must be anticipated; and lastly, the physiological action of the narcotic drug employed must be thoroughly understood. It is, of course, obvious that time or opportunity cannot always be found for the observance of these injunctions; but whenever it is practicable, an attempt to follow them should certainly be made." Further on he adds: "Each case should be carefully considered, and not only should the most appropriate anæsthetic be selected, but the most appropriate method of administering it should be chosen; and when any doubt exists, the question should be made the subject of a short conversation between the operator and the chloroformist."

No one will question the applicability of these remarks to all cases of operation requiring the exhibition of an anæsthetic, and when we admit the propriety of a surgeon in planning an operation, to take into consideration the capability of his patient to bear the anæsthetic, we must not permit him, as operator, to shirk the responsibility incurred by its administration.

I, however, go further than the writer just quoted, and am inclined to insist that, whereas I lay it down as an axiom that the operator and the administrator of the anæsthetic are equally responsible for the immediate result of the proceedings connected with the operation:

that both of them should have a voice in the consultation at which the operation is determined, and the various steps of its procedure discussed; that both should thereby be fully seized of all the aspects of the case—such as the stamina of the patient, his endurance power, the nature of the operation, its probable duration, all contingencies connected therewith, and the quality of the anæsthetic to be used.

I advance the following reasons to support this opinion—The person who administers the anæsthetic is, during the operation, master of the situation, and at any moment during its procedure, if in his opinion dangerous symptoms arise, he can veto any further progress of the operation. Careful and observant anæsthetists soon know by experience that notwithstanding profound anæsthesia, the subjects of a severe operation are liable to feel a shock at the critical time of an operation so as to produce failure of the heart's action—in other words, sudden faintness and collapse, which must be met by prompt and immediate action often to avert fatal results. It is when such happens that what I must call synchronous action and co-operation must be taken by both concerned, operator and anæsthetist. The latter should, by his previous knowledge of the patient and nature of the operation, be ready to anticipate such critical moments by priming, as it were, the vital resources of the patient by ether inhalation or the hypodermic administration of subcutaneous stimulants to the heart's action. The previous consultations and discussions regarding the case would have enabled him so to have mastered every detail and feature of the operation that he would be ready to anticipate any contingency, so that no error should be permitted to occur. I may mention a few of these critical times:—In oophorectomy, the tightening of the ligature that isolates the ovary, as also in securing the ligature when tying hæmorrhoids—every anæsthetist of experience regards operations on the rectum with anxiety; the interruption of the circulation in an operation for aneurism; the evacuation of fluid from an ovarian cyst; or the plunging of a trochar into a cerebral abscess—all such critical times should be duly appreciated and anticipated by a careful anæsthetist, and such can only be done with the co-operation and assistance of the operator.

In addition, I am convinced that there should exist such sympathy and co-operation between the operator and anæsthetist, as would cement between them a mutual bond of confidence and professional *esprit de corps*, so that each should entertain the highest estimation as to the abilities of the other.

* *The Practitioner*, August, 1887, page 93: "The Selection and Administration of Anæsthetics, &c., &c."

I myself have experienced the misery of having been suddenly called upon to do a serious operation with a timid or strange anæsthetist—I must say the extra responsibility is not pleasant—I cannot better express myself than liken it to an instance of trying to fill a square hole with a round peg, and the leakage of confidence is somewhat in the same ratio as the square of the hole is to the round of the peg. I imagine some of my hearers to sarcastically exclaim—"Then I suppose no one should go into the water until he had learnt to swim," or otherwise enquire "how is a man to study the administration of anæsthetics if he must wait until he gains experience?" To this I reply—no one should attempt to administer an anæsthetic until he had carefully observed an expert give it, and then to further proceed with his studies by administering it under the supervision of an expert.

I know that some members here present are ready to advocate that a professional anæsthetist should be appointed to each hospital, whose duties should be to administer anæsthetics and do nothing else. This is a form of specialism which I hope will be discussed to-night, also that this official's liability as to the immediate results of operations will be considered. I, for the sake of argument, pose as being against the making of such appointments, and do so for this reason—that it should be the training of every member of the profession to properly give the anæsthetic, and at the same time properly grasp the responsibility of the situation.

In concluding these remarks which I have made with the view of initiating this discussion, let me point out that we must not lose sight of the fact that in this colony every death from anæsthetics has been made the subject of inquiry before a coroner's court. A coroner's court consists of twelve men, not always specially trained for making legal enquiries, nor remarkable for astuteness of intellect. Every person who administers an anæsthetic incurs the liability to face such a tribunal, and no matter how guiltless of any crime, carelessness or culpability, it is in the power of any one or two of these gentlemen to so influence their fellows to come to such a decision that would send a member of our profession before a higher court, with the brand of manslaughter upon him, as well as the onus of proving himself innocent. With such a possible contingency before any one of us, it behoves us to formulate some routine method or ethical rules for our guidance, so as to protect ourselves from the odium of a criminal prosecution, or the humiliation of a civil action for damages.

16 College-street, Hyde Park, Sydney.

POLIO-MYELITIS ANTERIOR SUB-ACUTA VEL CHRONICA.

READ BEFORE THE VICTORIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

BY W. SIMPSON FLETT, M.D., Ch.M. Edin.

Notes were taken of the following case with a view of bringing it before this Association at a much earlier date, but I hesitated doing so until sufficient time should elapse to test the validity of the recovery:—

HISTORY AND EXAMINATION.

A patient, E.G., married, aged 45, from a neighbouring colony, was induced, on the recommendation of a friend, to consult me this month two years ago, suffering from what I may call a double paraplegia of both extremities. Her helpless bodily state being not only a severe trial to herself, but a source of anxiety to her husband and family, medical advice was naturally sought, and, as usual, in different quarters, till at length the hopeless verdict was given that the patient would never walk, when their friends suggestion was acted on. Anything that affords a prospect of relief will be resorted to under such circumstances, and arrangements were accordingly made for a short, or if needs be, prolonged stay in Melbourne, in the event of a reasonable likelihood being held out that thereby the desired end might be realised. The patient was brought to me in a cab, but judging from the extent of the paralysis no satisfactory examination could be made under the circumstances. I preferred seeing her in bed, and therefore made an appointment to call the next day. Meanwhile the opportunity was embraced of eliciting what information could be gathered as to the character and mode of onset, and the circumstances attending or preceding the initiation of the muscular debility. I ascertained that they all (patient and relations) associated the origin of the illness with a shock previously received in connection with an accident to one of the children. The first indication of motor disturbance had, I was informed, been observed about four months prior to this interview. It commenced by a feeling of uneasiness in the back, followed by weakness in the feet, ankles, and knees. Walking became awkward, next difficult, and finally impossible, for the pæsis gradually increased till she was unable to use the lower limbs at all. Slight feverishness was remembered to have occurred at the outset, but not being beyond what they were accustomed to see in ordinary cold, did not otherwise attract particular attention, except that it preceded the paralysis. The upper extremities then became

affected. The fingers began to lose their power. The patient had to give up knitting and sewing, and even the use of knife and fork, so that she could not feed herself, and the motor powerlessness extended upwards, from point to point, till the arms were ultimately paralysed. Both upper and lower limbs were now useless either for action or progression, so that the maximum of motor impairment had been reached by the time I saw the case. The sensory functions were little interfered with, whether of special or common sensation, save sensitiveness to cold, slight numbness, and a feeling of "needles and pins." The organic reflexes were normal. The bladder and rectum were unaffected. Both superficial and deep reflexes were so greatly diminished as to be almost, if not altogether abolished. But the characteristic feature was the derangement of voluntary motion. The want of muscular power in the extremities, upper and lower, was very marked. The muscles of the leg were flabby and wasted, also those of the thigh, but the distal tissues worse than the proximal. Similar phenomena were present in the upper limbs—the extensors of the fingers being specially involved, and the muscles of the arms were flaccid and more or less atrophied. Not having come under my notice till the atrophic stage, it was too late to detect the electrical "reaction of degeneration," for in paralysed muscles that are likely to recover, as Professor Erb as shown, its special phenomena do not usually last longer than a few weeks, and by the time I examined the affected muscles some of them were responding well, not only to the voltaic, but to the Faradic current. Mentally marshalling the salient features thus collated, and keeping in view the following noteworthy points, the presence of a well-known spinal affection was not difficult of recognition.

PATHOGNOMONIC SUMMARY.

We had (1) the age between forty and fifty, (2) the pre-existence of shock, (3) the existence of particular premonitory symptoms, (4) the presence of a certain amount of initial febrile disturbance, (5) the sub-acute and gradual character of the attack, (6) the ascending order of implication (first the lower, then the upper extremities), (7) the derangement of motility as the outstanding feature (motor weakness giving place to paresis, and this in turn to paralysis), (8) the distribution of the paralysed muscles localising the lesion, and (9) the atrophy following the paralysis. With a combination so characteristic, there could be little doubt as to the condition being a very striking example of the disease first described by Duchenne, and

called polio-myelitis anterior sub-acute vel chronica.

I was now in a position to express a more hopeful opinion than had hitherto been given on the case, and though not positively vouching for a cure, I felt justified in stating, that under appropriate treatment, there was every reason to expect decided improvement, if not recovery. Perceiving that the disease had reached its climax, and evidently entered on the stationary period, I had confidence, especially considering the favourable aspect of the electric excitability, in being able to benefit the patient. Knowing, however, it would be a question of months, I asked them to give the matter mature consideration, when it was decided to try the issue, and the patient was put under my care.

REMEDIAL MEASURES.

At this point distressing myalgic and arthritic pains, somewhat resembling rheumatism, which are so frequently associated with muscular wasting, were complained of in the foot and ankle, and greatly disturbed the patient's rest. These I succeeded in permanently removing by means of spinal sedatives and nerve tonics. Counter irritation applied to the spine proved beneficial. A nutritious, light and easily digested diet was persevered with, and strengthening tonics were administered for the general health. Friction and electricity were kept up regularly and systematically, in order to favour the nutrition of the affected muscles. Gradual, but substantial improvement became apparent. The arms, first passively, then actively, were found to move more and more freely. The hands began to regain power, as evidenced by the use of a spoon, the holding of a cup and such like, and the progress was such that ere long the patient could feed herself, with very little, and latterly, without any assistance. The lower limbs also showed obvious signs of returning strength, as movement after movement came to be performed. The feet again acquired power, and soon manifested steadiness enough to enable the patient to stand. Day by day the continuous treatment, which was assiduously maintained for three months, produced some additional amelioration of the condition, till ultimately it afforded encouraging results. Step by step the power for walking was restored. The patient began to move about the house, to take short turns outside the verandah, subsequently to take walks in the open street, and by degrees, to be able to go longer stretches time after time, care being taken not to over-fatigue. Then, finally, the recovery was, I do not say absolutely complete, but so re-

markable, that the patient delighted and anxious to show her what her organs of locomotion could now accomplish, actually walked nearly two miles in order to say good bye, and intimate her intention of returning next day to her home and family circle, where she has been able ever since satisfactorily to superintend and manage her household affairs.

PATHOLOGY.

The nature and seat of the spinal cord lesion in this disease is extremely interesting. It consists of inflammatory and degenerative changes in the anterior horns of grey matter, the essential constituents of which are the multipolar nerve cells. Physiologically, these ganglionic cells are the trophic centres for the nerve fibres proceeding from them, and for the muscular tissue to which they are distributed. To these multipolar nerve cells also pass controlling impulses through the crossed pyramidal tract, voluntary impulses through both crossed and direct pyramidal tracts, and reflex impulses through the posterior nerve roots, while out from them proceed, per their axis cylinder processes, voluntary and reflex motor impulses to the entire muscular area within the sphere of their influence. Pathologically, therefore, any lesion in the anterior cornu of the spinal cord produces morbid effects precisely commensurate with the number of multipolar nerve cells destroyed on the one hand, and the rapidity of the destructive process on the other. Accordingly, in exact proportion to the acuteness and extent of the damage which these multipolar nerve cells sustain in any given diseased condition, will there be (1) diminution or absence of voluntary motion, (2) diminution or absence of reflex movements, and (3) presence of more or less atrophy, and the "reaction of degeneration" in the muscles over which they preside. When the destruction is incomplete, then the motor impairment, the reflex interference, and the atrophic changes will be correspondingly partial, and may so modify the "reaction of degeneration" that it is unobtainable. When confined to the anterior cornu the sensory functions are undisturbed, and the parts supplied by the posterior nerve roots are not affected as to sensibility. In short, we cannot state the consequences of a lesion of the anterior horn, without describing the essential symptoms of this case already narrated. The affection is not very common, and as the majority of those affected for the most part recover, the opportunity of examining the appearances post-mortem is rare, but in the few cases which have been recorded, there was found distinct evidence of chronic inflammation in the anterior cornual

region. Microscopically, the minute observation has revealed an alteration in the histological elements of the cord, which answers to the clinical phenomena interpreted by the amount of physiological disturbance, viz., (1) more or less extensive destruction of the multipolar nerve cells, (2) dilatation of the vessels, and (3) thickening of the connective tissue, with (4) the nuclei and Deiter's cells more prominent and in greater abundance than in health. Then with respect to the morbid histology of the paralysed muscles, it has been observed that the muscular fibres which are most seriously injured, lose their transverse striæ and become infiltrated with oil globules, that their nuclei are multiplied and the interstitial fibrous tissue increased, and that other fibres less implicated, undergo simple atrophy, while some are normal. The fact of complete recovery from the paralysis and atrophy sometimes taking place, would seem to indicate that the destruction of the multipolar nerve cells is not usually absolute, for there is no evidence that a totally destroyed nerve cell is ever regenerated. The distribution of the paralysis longitudinally, pointed in this case to the involvement of the lumbar and cervical enlargements.

ETIOLOGY.

Nothing very definite is known as to the causation of this ailment. As far as our present knowledge goes, it is exclusively a disease of adult life, being confined to persons between thirty and fifty years of age. One or other of such antecedents as exposure, shock, excess, or fatigue, has usually been traced as occurring sometime before the onset, but whether the association of these has any casual relation to the existence of the malady still lacks proof, though they might well be conceived as contributing to an attack. It is further recognised that plumbism produces motor symptoms indistinguishable from those observed in this disease, probably, in consequence of the lead exerting a toxic effect on the same nerve structures of the anterior cornual region of the cord. The precise etiological conditions, however, may be said to be unknown.

CLINICAL FEATURES.

These have been already before us in their most common and typical characters and do not require repetition, but we must not forget that though the disease, as a general rule, follows the order, course and termination exemplified by this case, yet it does not invariably conform to these lines. It will be necessary, therefore, to supplement the previous description of the symptoms by some further observations on

certain points not before referred to. A form occasionally presents itself in which the order is reversed, and in place of the disease commencing in the lower limbs, the upper extremities are the first to be attacked, and the legs subsequently. This, Duchenne termed the "descending type," the other, the "ascending type." Then instead of the process being arrested at a particular stage and terminating in complete or partial recovery, the mischief may, in some instances, continue to extend till it reaches the upper cervical region of the cord, and ultimately invades the medulla oblongata, when bulbar symptoms become developed, and the case ends fatally from respiratory complications. In other cases the disease may become more chronic. Recovery is then hardly to be expected, but the advance may be slow, and the patient may linger on for years.

DIFFERENTIAL DIAGNOSIS.

The distinctive points sufficient for the due recognition of the affection as such, have been already clearly and amply stated; but it has to be distinguished from at least three other morbid states, and in the early stage from a fourth:—

1. *Polio-myelitis Anterior Acuta*, in which (1) the age is rarely adult; (2) the onset is sudden, and fever considerable; (3) the paralysis attains its maximum at once, the subsequent changes tending towards improvement; and (4) the result is seldom fatal, but when so, occurs at the outset. In our disease on the other hand, (1) the age is always adult; (2) the onset is gradual and the fever slight; (3) the paralysis advances from part to part, and the maximum is never reached at once; and (4) usually ends in recovery, but when fatal, death does not occur so early, but from extension to the medulla.

2. *Progressive Muscular Atrophy*, in which (1) the upper extremities are in the majority of cases first involved; (2) the paralysis of the muscles succeeds, and is in proportion to the atrophy; (3) the individual fibres are invaded; (4) re-action of degeneration and abolition of reflexes do not appear till far advanced; (5) the disease is often fatal; and (6) the atrophied muscles do not recover. In our malady on the contrary, (1) the majority of cases become affected first in the lower extremities; (2) the paralysis is before the atrophy; (3) whole muscles or groups of muscles atrophy at once, not fibre by fibre; (4) the re-action of degeneration and abolition of reflexes are early; (5) the disease does not, as a rule, destroy life; (6) the atrophied muscles do not often recover.

3. *Lead Paralysis*.—With the typical local paralysis of plumbism there is no difficulty, but in certain cases where it is more general, the

motor symptoms are almost identical. Even then, however, (1) the history; (2) the occupation of the patient, or testing the drinking water; (3) the blue line on the gums; (4) the lead colic and rheumatism, ought to be sufficient to differentiate between it and the malady in hand.

4. *Typhoid Fever*.—In one case, while the febrile disturbance lasted, it was being carefully watched for typhoid, but on the fever passing off, the paralysis and atrophy became so well marked that it turned out one of the most characteristic examples of polio-myelitis anterior sub-acute vel chronica. The patient was a gardener, and the paralysis commencing in the lower extremities in his case, spread up and attacked even the intercostals. It is only at the initial stage such a difficulty could occur, but as it has happened, I thought it well not to overlook the contingency.

PROGNOSIS.

In most cases this is favourable as regards life. Some patients get completely well, but the majority, though making a very fair recovery, yet retain certain traces of the paralysis; while some prove fatal from upward extension of the morbid process to the respiratory centres; and others, becoming more chronic, are carried off by intercurrent complications.

TREATMENT.

This has already been mentioned, and nothing more need be added, as the means adopted fortunately proved satisfactory, and up to the last time I heard, there had been no return of the paraplegia.

Brunswick Street, Fitzroy,
Melbourne, June, 1888.

THE TREATMENT OF ENTERIC FEVER AT THE COAST HOSPITAL, NEAR SYDNEY.*

BY W. PEIRCE, MEDICAL SUPERINTENDENT.

It is usual to commence the treatment of enteric fever at the Coast Hospital by the administration of 3 to 5 grains of calomel in cases received within about the first 10 days of the disease. This appears to exert a favourable influence on the fever; not, however, I think, as frequently supposed, by generating mercuric perchloride internally and thus indirectly acting on the seat of the disease.

*This report, furnished by the Medical Superintendent of that Institution to the Medical Adviser of the N. S. Wales Government, was laid on the table of the Legislative Assembly on July 17, 1888.

If this were really the mode of action of the calomel, I should certainly expect that poisonous symptoms would in some cases arise; but fortunately this does not occur.

After the action of the calomel, provided that the kidneys work satisfactorily, acetanilide is given in 5 grain doses, and continued in the same doses whenever the temperature exceeds a certain point (101° to 103°) according to the case; up to 6 or 8 times in 24 hours, if necessary. After each dose the temperature generally falls perceptibly in about 40 minutes and attains its minimum in from 2 to 4 hours. The evident action of this drug, besides lowering the temperature, consists in diminishing the frequency of the pulse from about 6 to 20 beats per minute, with corresponding slowness of respiration, and at the same time increasing arterial tension, and inducing profuse skin elimination, thus very much diminishing the tendency to delirium and frequently quite preventing typhoid stupor. It also induces a remarkable feeling of ease and repose, which appears partly to depend on the production of a certain amount of peripheral anæsthesia. When the effect of acetanilide is passing off, the temperature frequently rises with great rapidity—like the sudden releasing of a gradually-compressed spring. Immediately on perceiving the elevation of temperature, the practice has been to administer another dose before the stupor and delirium, generally incidental to a high temperature, have had time to become manifest. This treatment, which neither shakes nor alarms the patient, has striking advantage over cold bathing in very many cases. It is found essential to take temperatures at least every two or three hours, day and night, in order to carry out this plan of treating fever properly; and I observe that the free and prolonged administration of turpentine, and of chlorine mixture, is more than ordinarily beneficial when aided by the regular use of acetanilide.

The appetite is observed to improve and the liability to inflammatory complications to diminish in most cases in which acetanilide has been given continuously for several weeks, and it certainly has the power of remarkably economising the patients' vital energy. It produces, as far as my observation goes, no permanent mischief, and it is not necessarily contra-indicated in cases of cardiac complications, whether they arise during the course of the fever or not. I gave the drug freely, with evident advantage, to a patient with typhoid fever, complicated with mitral regurgitation after acute rheumatism, and also with benefit in another case which had old mitral obstruction and hypertrophy of left ventricle. Besides giving rise to no unpleasant symptoms, the effect of acetanilide is to render the course of enteric fever milder than it

otherwise would be, but it probably may not lessen the duration of the disease. In all cases in which acetanilide is freely given there is a liability to the occurrence of occasional cyanosis of extremities and face, with irregular pulse; and I have sometimes noticed chills accompanying the rise of temperature when the action of the drug was ceasing. These symptoms are transitory, and can be adequately combated by the temporary suspension of the medicine and the occasional use of hypodermic camphor.

The use of alcohol in small doses, seldom exceeding 2 ounces of brandy in 24 hours, and generally only in cases of failing heart (especially when associated with asthenic delirium), has been lately the practice at the Coast Hospital. I feel convinced that the partial cerebro-spinal insensibility produced by persistent large doses of alcohol in typhoid fever is very injurious during a long illness, although it may induce a temporary soothing and beneficial effect. Long-continued stimulation means wasted nerve energy, necessarily accompanied by a corresponding diminution in the patient's ultimate probability of recovery. In treatment of enteric fever we are compelled to diminish the fuel employed to sustain life; we should therefore proportionately diminish, if possible, the fire that consumes it, and this can only be done by economising nerve-power, lessening muscular exertion, and reducing heat. Even when only occasionally used in the course of typhoid fever, it is evident that alcoholic stimulation means temporary exhilaration, due to increased cerebral circulation, and inevitably succeeded by proportional nervous depression, unless followed up by persistent alcoholic dosage. By its palpably injurious effects on respiration and on the functions of the liver and brain, the prolonged use of alcohol in enteric fever is answerable for many insidious deaths—the very natural culmination of a chain of neurotic symptoms intensifying towards the end, and insensibly gliding into coma.

Complications of pneumonia and pulmonary congestion have been treated by liniments and the internal administration of turpentine and creosote. Carbonate of ammonia was generally avoided in consequence of its irritative action on the bowels and its liability to induce diarrhoea. Chest complications were generally regarded as of secondary importance in comparison with the *enteric lesion*.

Delirium was treated with urethan, chloral, digitalis, veratrum viride, belladonna, ice to head, &c.

The treatment employed in intestinal hæmorrhage generally consisted in perfect rest, hypodermic ergotine, ice poultices to right side of abdomen and iced-water enemata, with also the occasional

administration of tannic acid, laudanum, and turpentine. Tannic acid and laudanum were, however, always used with great caution, as they certainly have a tendency to give rise to tympanites.

Ice poultices were applied, and turpentine was generally given in the treatment of tympanites.

Diarrhoea was treated with opium and starch enemata, acetate of lead, subnitrate of bismuth, ipecacuanha, &c.

Peritonitis was successfully treated with full doses of opium and absolute deprivation of food.

Hypodermic camphor and warm alcoholic drinks were given with advantage in cases of cardiac failure.

Symptoms of thirst throughout the disease were relieved by mild phosphoric acid drinks, and by applications of glycerine, &c., to the tongue and throat.

During convalescence, arsenic, quinine, phosphorus and iron were given with advantage.

It has been the custom to give only milk and beef-tea until between seven and fourteen days after normal temperature has been established, and then to give only sago or arrowroot for several days in addition to the former diet.

Very much injury has been caused by the visits of ignorant sympathising friends, not only by directly smuggling in biscuits, &c., but by injudicious conversation, exciting, fretting, and wearying patients, thus raising their temperatures and wasting their energies. This cause appreciably influences mortality statistics.

All thermometers are separately tested before being sent into the wards, and incorrect instruments are discarded. Observations of nurses are frequently checked by comparison with a standard clinical thermometer at the bedsides of patients.

I append a case which illustrates the general treatment.

Case illustrative of action of Acetanilide :—

Bessie Christison, aged 25, married. Two years in Australia. Admitted to Coast Hospital, 26 April, 1888. Over three weeks ill. Temperature on day of admission reached 105°. Febrile stupor existed, with dry parched tongue, weak and compressible pulse, bronchial râles, disturbed sleep, and distressing thirst. Prognosis very unfavorable. Highest temperature attained during illness, 106°. Lowest temperature attained during illness, 98.4°. Turpentine was given all through this case, with occasional doses of belladonna and digitalis; also urethan for sleeplessness. No alcohol was given until the forty-seventh day, and since that date only 6 ounces of port wine daily. As convalescence approached, phosphorous and arsenic were freely given.

A CASE OF CHOLECYSTOTOMY.

READ BEFORE THE SOUTH AUSTRALIAN BRANCH,
B.M.A.

By JOHN DAVIES-THOMAS, M.D. LOND., F.R.C.S.
ENG., JOINT LECTURER ON MEDICINE AT THE
UNIVERSITY OF ADELAIDE, AND PHYSICIAN TO
THE ADELAIDE HOSPITAL.

MRS. ELIZABETH M., resident at a township in Victoria, came under my care on August 19, 1887.

Her family history was good and offered no points worthy of comment; she was 42 years of age; had been married for ten years and had had two children, one of whom was then alive and nine years old.

Until three months previously she had menstruated regularly and normally, but since that time there had been a total arrest of this function; for about five years she had been subject to frequent attacks of vomiting which had been attributed to uterine disease, probably some malposition of the womb; these attacks, however, had entirely left her for the last two-and-a-half years.

Her present illness dated from September, 1886, i.e., nearly a year; it began with pain and swelling in the upper part of the abdomen; the pain was paroxysmal and was accompanied with abdominal tenderness but not with vomiting; the duration of these attacks varied, lasting sometimes for an hour or two, but as time advanced becoming more prolonged; during the last ten weeks there had been no pain, except what she attributed to flatulence, from which she had recently suffered. The abdominal distension was not constant and varied with the pain. Since March 1887 she had been jaundiced; she thought that this symptom had come on slowly; her motions were clay-coloured and her urine was dark. Lately she had been liable to "shivers" lasting for several hours, and followed by fever in which her temperature sometimes rose to 104° or 105°. She stated also that occasionally attacks of fever came on without being preceded by rigors.

Upon examination, I found her deeply jaundiced; conjunctivæ yellow; skin olive-yellow. The abdomen moderately distended with gas; no discoverable tumour; liver apparently of normal dimensions; lungs and heart normal; no albuminuria; urine deeply bile-stained; motions devoid of bile.

It was evident, therefore, that the jaundice was due to obstruction, and that by far the most pro-

bable cause of the obstruction was gall-stones. I accordingly advised an exploratory incision with a view to cholecystotomy if the diagnosis were found to be correct.

This was consented to by the patient, and, accordingly on August 27, with the assistance of Drs. Way and Lendon, Dr. Maunsell, of Dunedin, also being present, I proceeded to operate as follows :—

An incision about three inches long, commencing at the right margin of the rectus, was carried horizontally outwards, nearly parallel with the right costal margin, and the tissues were divided in the usual manner ; no material bleeding occurred and no vessels required ligature ; when the peritoneum was divided bile-coloured ascitic fluid escaped in moderate quantity ; the fluid coagulated spontaneously in the vessel in which it was received.

This incision had been selected by me instead of a median cut because I was convinced that no material enlargement of the gall-bladder was present, and this opinion proved to be correct, for only the rounded fundus of the gall-bladder projected beyond the margin of the liver ; a piece of omentum protruded into the wound but was easily held aside ; the under surface of the bladder was now examined with the finger as well as the course of the cystic and common bile-duct as far as this could be traced towards the duodenum ; in the gall-bladder numerous calculi could be felt through the wall, but neither by my colleagues nor myself could anything suggestive of a gall-stone imbedded in the common duct be felt, although special attention was paid to this point.

The ascitic fluid having been allowed to escape as completely as possible, a modification of Keen's shoe-horn funnel was slipped in underneath the gall-bladder so as to prevent escape of bile into the abdominal cavity ; two parallel loops of stout silk were then passed through the fundus of the gall-bladder so as to command the opening which was made between and parallel to them ; the incision was made of sufficient size to easily allow of the insertion of the index finger ; with the aid of a forceps 21 calculi were removed, the last one of which had formed a small pouch at the point of origin of the cystic duct ; after a careful exploration with the finger and a flexible metal sound so as to leave no discoverable stone behind, the lips of the opening in the gall-bladder were stitched to those of the parietal incision by numerous silk sutures which included the peritoneum. An abundant flow of bile took place during the operation, but only after the removal of the calculi ; an india-rubber drainage tube was inserted into the gall-bladder ; iodoform and protective were applied to the lips of the wound and an anti-

septic dressing of wood-wool with a backing of oakum, the whole being enclosed in alembroth gauze, was employed.

In the evening the dressing was changed, there having been a copious discharge of bile ; her temperature was normal ; the jaundice had evidently become less marked and she complained only of occasional slight colicky pains in the abdomen.

It would be tedious to report at length the subsequent history of the case ; it will suffice to state, that on the 4th day two of the sutures were removed and a considerable amount of union had taken place ; on the fifth day she passed a motion which contained abundance of bile ; on the next day the same thing occurred ; on the seventh day several more stitches were removed ; on the ninth day she left her bed and sat up for an hour-and-a-half ; a copious discharge of bile took place from the sinus, the jaundice gradually faded and the urine became less bile-stained ; but on the twelfth day it was noted that a motion containing very little bile had been passed and that the outflow through the sinus was very profuse ; on the thirteenth day she had recovered sufficiently to leave the Private Hospital for a friend's house ; after this time, the discharge of bile from the sinus continued copious although the opening soon contracted to the size of a pin's head ; the motions showed scarcely any bile but the jaundice gradually disappeared, and the urine ceased to contain bile ; her general health was excellent and she gained flesh ; however the constantly recurring escape of bile was a source of great annoyance to her ; accordingly I endeavoured to check it by the application of an india-rubber air-pad secured by a body-bandage ; this however proved quite useless. On the 61st day after the original operation I performed a plastic operation with the hope of closing the fistulous opening ; the operation consisted simply in paring freely the lips of the wound and passing deeply a couple of silver sutures, and also a third one inserted at a distance of three-quarters of an inch from the lips of the wound but passed only through the skin ; the object of the latter stitch was merely to relieve the principal stitches of any strain upon them.

This operation was not successful in closing the sinus and the patient certainly felt ill when the outflow of bile was hindered ; in the course of two or three days the sutures were removed and no further attempt was made to close the outlet, as it was clear that some obstruction still remained to the passage of bile into the intestine. Shortly afterwards the patient returned to her home in Victoria.

For several months I heard nothing more of the patient, but on March 6 of this year she wrote to me and stated that she was keeping pretty well

in general health but that the bile still continued to flow from the fistula, and that she thought no bile passed with the motions.

I afterwards learnt that Mrs. M. had died and that a *post-mortem* examination had been made by Dr. Ryan, of Nhill; I accordingly wrote to this gentleman who most kindly has supplied me with a report of the fatal illness as well as with a very interesting account of the *post-mortem* examination, of which the following is an abstract.

The patient was attending to her household duties until March 18, on the evening of which, after a day of clothes-washing, she felt dragging pains in the back and down the front of the abdomen; the pain, which was of an intense, shooting and darting character, was sufficiently great to keep her awake at night; the pains, although principally abdominal, occasionally extended to the insides of the thighs; next morning she became much jaundiced and vomiting came on; the urine which she now passed resembled blood and her abdomen began to swell; when seen by Dr. Ryan the patient was markedly jaundiced, lying on her back in bed with her legs drawn up; she suffered from extreme abdominal pain and vomited frequently; the abdomen was tympanitic and tender, and there was also tenderness in the lumbar regions, especially on the left side; by means of a catheter a few ounces of dark red fluid, devoid of urinous smell and resembling venous blood, were removed from the bladder; there was no vaginal discharge; the liver dulness was somewhat increased in area; the fistulous opening left by the operation had about the dimensions of a pin's head. Her condition remained pretty much the same for the next few days, during which she had a discharge of blood from both the rectum and the vagina; she died quietly on March 23, ten days after the onset of her last illness. The temperature throughout was not known to have exceeded 100°.

POST-MORTEM EXAMINATION BY DR. RYAN.

Body well-nourished; marked jaundice; about three pints of serous fluid in the peritoneal cavity, but no trace of peritonitis; there was a large extravasation of blood behind the peritoneum in the lumbar region; this surrounded both kidneys but especially the left one, and the infiltration extended into the pelvic cellular tissue; on removing the kidneys, a quantity of extravasated blood was seen beneath the capsule; the organs themselves were fibro-fatty; there were small clots in both kidneys and the left ureter also contained a few small clots; in the urinary bladder were about two ounces of dark blood, partly coagulated.

The liver was somewhat enlarged; pale yellow in colour, soft, friable, and fatty; no gall-stones could be found in any part of it. The gall-

bladder was empty; capable of containing about five ounces of fluid; from its fundus a fistulous channel ran obliquely through the abdominal muscles to the surface.

The common bile-duct was about half an inch in diameter and was plugged, though not completely, by two small roundish plugs of inspissated bile of very moderate consistence, easily breaking down under pressure of the fingers; this plugging was about one and a half to two inches from the duodenal opening; there were no gall-stones in the duct; the mucous membrane of the duodenum was bile-stained; its calibre was somewhat contracted by the extravasation beneath the peritoneum; the head of the pancreas was about twice the normal size and was thoroughly saturated with blood, which oozed out on section; the tissue of the head crumbled down readily on pressure into a dark brown debris of blood and granular matter; the extravasation in the pancreas was continuous with that into the cellular tissue adjacent: no opening of a vein or artery could be discovered, nor was there any sign of malignant disease.

Dr. Ryan regarded as the cause of death hæmorrhage from the pancreas, probably from a large vein, and he thought that this was induced by over-exertion whilst engaged in her domestic duties.

This case presents several points of interest.

1. There was no enlargement of the gall-bladder; this neither contra-indicates nor renders difficult an operation.

2. No calculus could be felt in the course of the common bile-duct, and on several occasions after the operation the stools contained abundance of bile and yet a little later no bile appeared in the stools; this continued until death, and yet strangely enough, Dr. Ryan, in his report of the *post-mortem* examination, states that the mucous membrane of the duodenum was bile-stained.

3. The common-bile-duct was notably dilated and was obstructed though not occluded by inspissated bile.

4. The locality and character of the fatal hæmorrhage were most remarkable and to the best of my belief were unique.

I need not remark upon the great value of the operation of cholecystotomy, for it may now be regarded as being as necessary and safe in its domain as lithotomy is in the case of vesical stone. I may remark that Mr. Lawson Tait reports in the *Lancet* of April 14, 1888, eleven additional cases of this operation, making, with thirty previous cases operated on by him, a total of 41 cases with only two deaths. Surely, when we reflect upon the intense pain that constantly, and the great danger that frequently, accompanies

gall-stones, we should not hesitate to urge this measure of relief on our patients who suffer from this disease.

In the *American Journal of the Medical Sciences* for October 1884, there is published an interesting record of the cases of cholecystotomy up to that date, as well as two new cases; the article in question is written by Drs. Musser and Keen, of Philadelphia.

REMARKS ON SUPRA-PUBIC LITHOTOMY IN YOUNG CHILDREN.

READ BEFORE THE SOUTH AUSTRALIAN BRANCH,
B. M. A.

By ALFRED A. LENDON, M.D. LOND., LECTURER ON FORENSIC MEDICINE, UNIVERSITY OF ADELAIDE.

DURING the past twelve months I have operated for a vesical calculus by the supra-pubic method upon three young boys at the Adelaide Children's Hospital; in each case the rectum was distended with the bulb of a spray-producer as a substitute for Petersen's bag, and the bladder washed out, and then distended with boracic acid lotion. The skin incision in no case exceeded one and a-half inches, and the wound of the bladder was probably much shorter; the bladder was never sutured, but the skin wound was brought together with horsehair, and a drainage tube inserted which projected into the bladder. The progress of each case was satisfactory, and I append details in a tabular form:—

Name.	Age.	Weight of Calculus.	Drainage tube left out.	Passed Urine per Urethram	Ceased passing Urine through Wound.
W. O'K.	4	58 gr.	2nd day	11th day	13th day
T. P.	1½	100 „	same day	8th day	9th day
H. C.	8½	45 „	3rd day	7th day	19th day

Had the proper instruments been available I should have performed litholapaxy in preference to lithotomy, as I consider that the experience of Surgeon-Major Keegan and others proves its superiority. But having to choose between perineal and supra-pubic lithotomy, the question to be decided was which would be the better operation for one who had no special experience of vesical surgery. We are always told that perineal lithotomy in children is such a satisfactory operation, both as regards the mortality rate, and the facility with which it may be performed, and my own hospital experience confirms this view. We do

not hear so much about the unsatisfactory after-consequences, but that they occur more frequently than is suspected, I am quite satisfied. In Adelaide I have been told by the operators themselves of cases where a fatal result has followed from some difficulty in the performance of the operation, of incontinence of urine persisting for years afterwards, and I know personally of one instance of recto-vesical fistula ensuing which has hitherto defied plastic operations, and lastly of a case in which the stone was not found at the first operation, which had to be repeated subsequently, and which resulted in a serious stricture of the urethra. As regards sterility ensuing from damage to ejaculatory ducts, I know nothing. On the other hand, my only previous experience of supra-pubic lithotomy in a young child was when I assisted one of the most brilliant surgeons of the West of England, who is also a recognised authority on abdominal surgery. In this case, when the bladder was opened, the stone could not be found, the operation was abandoned and the child died; *post mortem*, the diagnosis was found to be correct, but after the escape of urine the surgeon had made a fictitious cavity with his finger in the cellular tissue, into which the urine escaped, and which on inspection had a most fallacious resemblance to the bladder. In my first case, the stone had been suspected but not actually detected with the sound, until it came under my care, the reason being apparently because in some inexplicable way it was lodged above or behind the pubes. I thought it, therefore, a favourable opportunity for operating above the pubes, and the success of the case encouraged me to repeat the operation in the other instances. I encountered no real difficulty until the bladder was opened, although the shortness of the incision and the depth of the wound made it much less easy than in the adult. When the urine had escaped, I found that even with catch forceps on the edges of the bladder it was difficult to extract the stone, and even to grasp it, as I laboured under the disadvantage of not being able to keep a finger in the bladder on account of the forceps being relatively of large size as compared with the bladder wound and the calculi themselves. I did not suture the bladder as I thought the edges had probably been bruised, and I do not think that in the case of children, whose secretion is limpid and bland, the dribbling of urine over the pubes and groins is a matter of great moment.

In future I intend to perform litholapaxy, but as regards the cases I have recorded, I think that my experience justifies the preference for the high operation as a safer, although much less rapid and brilliant operation than the perineal one.

**SEVERE SLOUGHING OF THE SCROTUM
FROM URINARY EXTRAVASATION—
PERINEAL INCISION, WITH DRAIN-
AGE—RECOVERY.**

BY THOS. BAIN WHITTON, M.D., Q.U.I., &c.,
REEFTON, NELSON, N.Z.

PREVIOUS HISTORY.—John C., aged 48 years, a powerful and active man, married; who never had any previous trouble with his urinary organs, nor had suffered from any illness, was engaged in the laborious occupation of a coal miner, he had, as well as raise the coal from the pit, to deliver it to his customers, which caused him frequently to get thoroughly wet, after having been, perhaps, a few hours before in a state of profuse perspiration.

On September 11, 1887, he received a more severe wetting than usual, followed by several attacks of rigors; and to improve matters, "he went on the spree" and fell asleep in his damp clothes. Next morning, he was able but to pass a few drops of urine at a time, and complained of a severe pain over the region of bladder; he had received no injury of any kind to the scrotum or perineum, but as he was still drinking he paid no attention to his condition, until complete retention of urine set in, which occurred on the 13th. During the next 24 hours his friends attempted to relieve him by warm applications, &c., but all such methods having proved ineffective, he was sent to me; I easily passed a No. 7 elastic catheter into the bladder, withdrawing about two pints of clear, non-offensive, urine. Though he was relieved from the distention of the bladder, he still felt a constant pain in the perineum, with a desire to urinate frequently, and looked so ill, that he was sent to Reefton Hospital.

He was ordered to remain in bed, and to take two drachms of this mixture every two hours:—
℞—Pot. Bicarb. ʒiij., Tinct. Opii, ʒij, Liq. Ammon. Acet. ʒj., Tinct. Nux Vomica. ʒj., Inf. Buchu ʒvj.

He slept during the night, and in the morning (15th) he passed a quantity of urine freely, which was clear, acid and without albumen or lithates. Both an olivary elastic catheter and a rubber one, No. 7, were inserted, but it was impossible to pass them beyond the membranous part of the urethra; yet, during this and the two following days (16 and 17) urination was free and painless; in fact so well did he feel that he was allowed to walk about the ward, and would have been discharged in a few days. On the 19th he had gone to bed feeling as well as usual, when at 2 a.m. he awoke with a severe rigor, which was followed by several

more, and then found that he was unable to pass any urine, but that the perineal pain was very acute. Stimulants having been freely given, and warm applications applied to the abdomen, the rigors ceased. On examination, a soft, compressible swelling, about the size of a marble, but returning again on the withdrawal of the fingers, was found over the membranous part of the urethra; on its compression a distinct gurgle was audible, somewhat like that which is heard on the reduction of a hernia; the catheter could not be passed beyond this swollen part, yet as much urine was drawn off as if it had entered the bladder. Complete rest in bed, with a milk diet and an ounce of whisky *ter die*, was now insisted upon, as it was evident that extravasation of urine had occurred; the usual symptoms of which rapidly followed, swelling of the cellular tissue of the scrotum and penis, and the lower part of the abdomen, frequent rigors with vomiting, foul tongue, temp. 103° and pulse 115, the urine, which is ammoniacal and offensive, drains away on leaving a catheter in the urethra. The swelling has now (20th) become as large as an egg, and when it is compressed urine flows freely from the penis.

21st.—Both the scrotum and penis are greatly distended; the skin is dull red and boggy, with a tendency to slough. After a little patience a No. 3 gum elastic catheter entered the bladder, but no urine flowed, as the cellular tissue of the perineum and scrotum has become the urinary receptacle, which drains through the urethra if kept open. He has now become anxious and restless, with a tendency to tympanitis, and vomited frequently after the insertion of the catheter. Pulse, 120; temp., 104°. The mixture was discontinued and he takes milk and soda frequently; an injection of $\frac{1}{4}$ gr. of morphine was given at 9 p.m., after which he slept for four hours.

22nd.—The cellular tissue is so brawny and tense, that several free incisions were made on each side of the scrotum, after which poultices were frequently applied, and the retained catheter was dispensed with, since it only increased the vomiting and resembled tapping a tank a few inches below the water line, instead of at its base. Pulse, 120; temp., 103.5°; morphine, gr. $\frac{1}{2}$, again injected to-night.

23rd.—Gangrene has now set in; those incisions made yesterday are black and sloughing, the scrotum is enormously distended, cedematous, and of a glossy red appearance. The urine is foetid, in fact, he exhales a urinous odour, and it is evident that unless the urine can obtain a free course from the bladder to the surface, he will speedily die. A perineal incision was performed, being placed in the usual lithotomy position, with-

out any chloroform, a medium sized staff was passed as far down as the membranous part of the urethra, when a sharp bistoury was steadily pushed into the raphe of the perineum, until it touched the staff, it was then carried down so that the incision was $\frac{3}{4}$ in. in length, and about $1\frac{1}{4}$ in. from the anus. The urethra was fully opened, no hæmorrhage followed, but a gush of foul smelling urine occurred, the bladder was syringed with a warm boracic acid solution, the poultices were discarded, and a large sponge, surrounded with layers of tenax was placed under the anus, so as to absorb all discharges. The vomiting ceased; he is in a weak typhoidal state, with extensive tympanitis, subsisting on milk and whisky, with a pulse 125, and temp., 103° ; morphine as usual.

24th.—The urine drains freely through the incision, into which a medium sized red rubber drainage tube, four inches long, was passed downwards into the urethra, but too large to enter the bladder, and was cut off flush with the perineum, both to keep the opening patent, and not to interfere with the sponge. The scrotum is neither so large or cedematous to-day, and the tympanitis is subsiding; the lowest part of the left scrotum has sloughed away to the extent of a two-shilling piece, exposing the testicle. Temp., 101° ; pulse, 116. He was given two drams of this mixture every four hours:— \mathcal{R} —Tinct. Quinine, \mathfrak{z} ijj. (grs., xxiv.); Spts. Chlorof., \mathfrak{z} j; Spts. Frumenti, ad \mathfrak{z} vi.

25th-27th.—A large cavity, which contains ash-coloured layers of decayed cellular tissue, saturated in serum and urine with an abominable fætor which taints the whole ward. The urethra, &c., is daily syringed with boracic acid; all sloughs are clipped freely away with a scissors, and the exposed surface of the testicle dressed frequently during the day with layers of lint and Condyl, the sponge being also changed twice daily, one being always in the same disinfectant. His back is threatened with bed sores, and the size of the scrotum prevents him being changed to his side, but "Jowsey's Patent bed," which allowed of his back and both thighs being elevated to any angle, gave him great ease. Pulse, 120-115; temp., 100° - 99° .

28th-30th.—Nearly all the sloughs around the testicle have been removed, it has but a layer of fascia around, and resembles a yellow-coloured pear, hanging down through a ragged and gaping cavity around which the finger can be passed up the cord. The gangrene is also extending rapidly along the floor of the perineum; he was at the worst to-day (30th), semi-conscious, passing involuntary motions, and the milk even not retained on the stomach, for which beef-tea was substituted with benefit, and whisky was not neglected.

As both Condyl and carbolic oil had no effect in allaying the fætid odor, the cavity was thoroughly syringed with a solution of zinc chloride (grs ij ad. \mathfrak{z} j) and after a short time a marked lessening of the smell was detected. From now until sloughing had ceased, this solution was daily employed, sometimes oftener, draining away through the tube. The cavity was then packed with lint soaked in carbolic oil. Pulse, 120-110; temp., 99° - 100° .

October 1-7.—As granulations are abundant over the upper part of the testicle and scrotum, half-a-drachm of iodoform is dusted after the syringing; the testicle is gradually retracting towards the original canal, which now allows of the edges of the wound to be drawn together; but there is still an extensive opening in the perineum, in which the course of the penis and the membranous portion of the urethra, with about three-quarters-of-an-inch of it sloughed away, can be seen. The catheter was passed down, and when viewed with a bright light, was visible and uncovered by any tissue for that length. He was out of bed to-day (3rd) to urinate through the perineum on a commode, hitherto the urine was passed in bed and absorbed as described; morphine was discontinued (7th) as he can rest well without it. He has wasted greatly, but his appetite has so improved that he can now make use of more substantial diet than beef-tea. Pulse, 115-100; temp., 99° - 100° .

8th-20th.—As all the sloughing has ceased, the zinc chl. solution was stopped and the boric acid resumed; iodoform is freely used over all the wound, and since the testicle has disappeared from view, the edges were drawn closely together by seven chromicised gut sutures, and using a 20% solution of cocaine, the operation was painless; iodoform, carbolic gauze, and a suspensory bandage completed the dressing, which kept everything in close contact, and in order not to cause a separation of the parts, he was allowed out of bed only to urinate. However, in five days, these sutures became so soddened and soft that they came away, partly from tension, and from the slight oozing of pus which was still present. Both the pulse and temperature are now normal.

21st-31st.—After the wound had been left open for a few days, and the edges pared, two silver-wire sutures were inserted in the form of a loop an inch long and well twisted; from being seven inches in length the wound was now but three inches. This method was effectual in keeping the edges in close apposition, and also allowed him to walk about, they were not disturbed for over a month, when the wound was closed. A powder, composed of iodoform and boracic acid (1 to 4) was dusted over the part and retained by

thin salicylated plaster. Maltine, two drachms bis die was substituted for the quinine mixture. The incision now began to close up, and the tube had been gradually shortened, so that now it did not exceed $1\frac{1}{2}$ inches, causing some trouble in its insertion.

November 5-27.—He informed me, that to-day (Nov. 8) he had passed urine through the penis, which, on inspection I found was a fact, and that none escaped through the scrotal wound; the drainage tube was withdrawn and the sinus rapidly closed. His weight is 10st. 11lbs. He was discharged (20th) to use the dusting powder himself; and in a week's time returned when the sutures were removed. A few granulations were noticed amongst the rugæ; the urine escapes per urethram, of which regained power he is very proud, but he was prouder still, when on meeting with him (April 1888), he informed me that his sexual powers were as effective as before his illness. The scrotum showed but a short, thin, scar; the testicle was almost on a level with the right one, and the fact was hard to realise that so extensive a sloughing should have left behind no damaged parts, or functions.

Remarks.—It must be inferred that the membranous part of the urethra had ruptured from the distention of the bladder, before I passed the first catheter; a slight vent, through which the urine oozed slowly into the cellular tissue, when cellulitis and extravasation suddenly set in with the occurrence of the rigors. The marked relief which followed the perineal incision; the benefit derived from the zinc chloride in lessening the slough and its fœtor; the rapid granulation with iodoform; the necessity of wire sutures being employed; and the power of restoring lost tissues, which nature can often exert, are facts to be noted in this case.

REPORTS OF SOCIETIES.

MEDICAL SECTION OF THE ROYAL SOCIETY OF NEW SOUTH WALES.

Monthly meeting held on August 17, Dr. Knaggs in the chair. Present—Sir Alfred Roberts, Professor Anderson Stuart, Drs. Shewen, Sydney Jones, Caruthers, Roth, Goode, West, Worrall, Fairfax Ross, Crago, MacLaurin, Kendall, Fiaschi, Hankins, Mander Jones, O'Reilly, Chisholm, Scot-Skirving, Twynam, Norton Manning, McCulloch, Murray, Oram, MacCormick, Jenkins. Purser and Riddell (visitors).

The minutes of the previous meeting having been confirmed, Dr Jenkins read the following paper on

THE TREATMENT OF TYPHOID FEVER.

"The subject of the treatment of typhoid fever is one of vast importance and great interest, for every year this insidious and preventable disease carries off many in the prime of life, wastes the valuable time of some,

and cripples others both mentally and bodily for the rest of their existence. There are those, no doubt, who will remark that very little good can be gained by a discussion on such a written to death subject as the treatment of enteric fever; on the other hand, it is certain that the modes of treatment practised by members of our profession are very variable, and the results surprisingly different. There has been lately published a paper from the 'Board of Health Department' entitled, 'Typhoid Fever in Sydney and Suburbs, from 1876 to 1888,' and ordered by the 'Legislative Assembly to be printed, June 26, 1888,' and interesting facts with reference to the prevalence and mortality of the disease have been disclosed. Thus it has been shown as far as statistics are concerned, that of late there has been a considerable and progressive diminution in the typhoid mortality. For example, in 1886 the rate of death per 100,000 was 90.90; in 1887 it was 58.11, and for the first five months of 1888 it was 30.97, as against 38.16 in 1887, and 62.17 in 1886; and special attention has been drawn to the very satisfactory results obtained at the 'Coast Hospital,' Little Bay. I will not weary you by giving the statistics of the earlier years, but will confine my attention now to the consideration of the mortality at our four large Hospitals for the years 1886, 1887, and the first five months of 1888, as given in the Government Report I have alluded to, and also for the chief Hospitals in Brisbane and Melbourne.

1886.	Cases.	Deaths.	Mortality.
Coast Hospital	395	56	14.18%
Prince Alfred	197	32	16.24
Sydney	108	24	22.22
St. Vincent's	79	11	13.92
1887.			
Coast Hospital	286	36	12.59
Prince Alfred	161	22	13.66
Sydney	72	12	16.66
St. Vincent's	59	13	22.03
1888.			
Coast Hospital	162	6	3.70
Prince Alfred	115	19	16.52
Sydney	65	21	32.30
St. Vincent's	66	7	10.60

Melbourne Hospital.

1886—397 cases.	48 deaths.	Mortality 12.09
1887—408 "	55 "	" 13.47
1888—260 "	49 "	" 18.84

(To June 30th.)

Alfred Hospital, Melbourne.

1887—342 cases.	39 deaths.	11 per cent.
1888—300 "	34 "	12 "

Brisbane Hospital.

Mortality, 1886—14.2 per cent.
" 1887—11.5 per cent.
" 1888—8. per cent.

"Presuming these statistics to be fairly accurate, it will be noticed, first, that a larger number of cases of typhoid are treated at the Coast Hospital; this in itself would, to a certain extent, account for a lower rate of mortality, and secondly, the very high death-rate at the Sydney Hospital in 1886, 22.22 per cent., and for the first five months of 1888, 32.30 per cent., and for St. Vincent's in 1887, 22.03 per cent. But what attracts attention more than anything else is the extremely low death-rate at the Coast Hospital for the first five months of 1888, viz. :—162 cases, 6 deaths, 3.70 per

cent. In order if possible to ascertain the cause of this low death-rate, the 'Board of Health' requested the Medical Adviser to the Government to be good enough to obtain from the Medical Superintendent of the 'Coast Hospital' a report as to the treatment he adopted. The Superintendent, in a letter to the Medical Adviser, duly published, states 'the constant kindly attention of the nurses, under the able and cheerful direction of the matron, was also an absolutely essential factor under Providence in producing beneficial results.' A full report of the treatment adopted is then given, and the principal points seem to be as follows:—(1) a dose of calomel, three to five grains, is given in cases received within about the first ten days of the disease; (2) acetanilide (antifebrin) is then given in five grain doses whenever the temperature reaches a certain point (101° - 103°) 6 or 8 times in the 24 hours. After each dose the temperature falls in about 40 minutes, and reaches the minimum in 2 to 4 hours; the pulse and respiration are lowered; the tendency to delirium and stupor are diminished. When the temperature rises again another dose is given. Turpentine and chlorine mixture are freely used, together with antifebrin. No permanent mischief appears to be produced by the antifebrin. Rigors and cyanosis have been observed.

"In cases of failing heart two ounces of brandy are given in the 24 hours, but stimulants generally are deprecated.

"Chest complications were regarded as of secondary importance in comparison with the 'Enteric lesion.'

"The treatment of other complications was carried out as generally advised in the ordinary text-books.

"The baneful influence of visitors was recognised.

"Now, although the mortality has diminished considerably during the last two years, I do not think we are justified in attributing the fact to any improvement in our sanitary arrangements, for we know there is great variation in the severity, and consequently in the mortality of epidemics. For example, in 1876 the death-rate per 100,000 was 46.07 per cent., with a population estimated at 167,141; in 1878 it was 90.76 per cent., with a population of 182,889; in 1881 it was only 41.74 per cent., with a population of 227,653; in 1885 it was 102.17 per cent., with a population of 282,845; in 1886 it was 90.90 per cent., with a population of 323,180; in 1887 it was 58.11 per cent., with a population of 340,702. From these figures it will be seen the mortality in the epidemics of 1878, 1885, and 1886 was extremely high.

"It has been well remarked that the value of statistics depends on the complete uniformity of the facts observed, and upon the accuracy with which the observations are made; and great care should be taken in forming an opinion from a comparison of statistics taken from a limited period. Statistics to be reliable must be based upon a large number of cases extending over a series of years. Dr. W. Selby Church, in a paper on typhoid published in the St. Bartholomew's Reports, states—'Favorable statistics can easily be obtained from any form of treatment not directly harmful—and every new line of treatment is pronounced successful for a time.' Now in the report of the Coast Hospital for 1884, the low death-rate of 10.63 per cent. is put down to (1) the careful selection of cases, (2) to the skill and unremitting care of the medical superintendent, (3) to the excellent nursing, (4) to the free ventilation. What is the low death-rate at the same hospital for the first five months of the year due to? The Superintendent and all those in authority under him are certainly to be congratulated on the good result, and we hope at the end of the year

the statistics will be equally satisfactory. In the first place there can, I think, be very little doubt that owing to the careful selection of cases, only mild forms of the disease are sent to the 'Coast Hospital,' and Dr. F. M. Smith, formerly Superintendent of the Hospital, bears me out in this in a letter written to the *Sydney Morning Herald*, July 17, 1888. Given, therefore, a large number of mild cases—many of them probably being of that type commonly known as 'febricula'—it stands to reason the mortality must be lower than at the 'metropolitan hospitals,' where the cases are not so numerous, and are generally admitted in a late stage of the disease. I can speak from experience as regards Prince Alfred Hospital, for during the two years I was Superintendent (1884-1886), a majority of the typhoid patients were received in a serious condition, with high fever, dry tongue, sordes, and many died shortly after admission. The statistics for the first six months of this year of Prince Alfred Hospital, have been most carefully prepared by Dr. MacAlister, the Resident Physician. There were admitted 144 cases, with 24 deaths, giving a mortality of 16.6 per cent.; but if we include 19 cases of febricula, the result is—163 cases 24 deaths, or a mortality of 14.72 per cent. Of the 144 cases of typhoid proper, no less than 41 were admitted in the third week of the disease, and 43 on the fourteenth day of the disease; one died on the day of admission, three died on the third day after, and eight died within the first week, thus out of the 24 deaths no less than 12 occurred within the first week. This fact alone shows the severity of the cases admitted into 'Prince Alfred Hospital,' and judging from the high mortality at 'Sydney Hospital' and 'St. Vincent's,' it is more than probable the cases admitted there were just as severe. There can be no doubt also that the stage of the disease at which efficient treatment is begun, has a manifest influence on the result, and recovery was the rule almost without exception in the cases admitted into Prince Alfred Hospital during the first week of the disease, and their stay in hospital was comparatively shorter. I feel quite certain the free ventilation at, and the pure atmosphere surrounding the 'Coast Hospital,' has a great deal to do with the low mortality there; and, as bearing on this point, the following from a paper read by Dr. A. S. Joske, at the Medical Congress, Adelaide, is interesting. Dr. Joske gave an account of 69 cases of typhoid treated in the 'Fever Camp' attached to the Alfred Hospital, Prahran, Melbourne. The death rate in the camp cases was 11.5 per cent., as compared with 12.6 per cent., the death-rate of the cases treated in the wards of the hospital at the same time. Dr. Joske found the temperature could be lowered by allowing the cool evening breezes to blow right through the tents, and without causing any lung complications; and Dr. Alex. Sokoloff (Russia), found that typhoid patients never suffered in any way from being in tents in which at night the temperature fell to 17 or 32 F., and no collapse ensued when the temperature of the patient fell from 104° to the normal. He therefore tried inhalations of artificially cooled air in typhoid patients with most satisfactory results. At Prince Alfred Hospital, acute cases of pneumonia treated in the cottage wards, where there is extremely free ventilation, do remarkably well. The 'Coast Hospital' being at such distance from the city, the visits of friends cannot be frequent, the patients therefore have a much better chance, for everyone is agreed that relations and friends are a source of great danger, not only exciting the patient, and increasing generally the severity of his symptoms, but also by administering secretly forbidden articles of diet. Rises of temperature occur so frequently, that one can sometimes tell the

visiting days by inspecting the temperature charts. On this point, Dr. Hare, of the Brisbane Hospital, writes to me as follows:—'All the fever cases here are treated in special wards, isolated from the rest of the hospital, and visitors are never allowed inside except to see dying patients. When they have been, the effect on the patient is to cause increased rise of temperature, and frequently to raise the temperature that previously had been normal, combined with which of course, is a certain amount of restlessness and insomnia.'

"Now comes the important question of treatment by drugs, baths, &c., and here there exists great difference of opinion:—

"(1.) As to 'Calomel,' which, as before stated, is used systematically at the Coast Hospital. Dr. Collier, at a meeting of the Oxford Branch of the British Medical Association, held November 3, 1886, laid stress on the value of calomel in the early stages of typhoid. Dr. Alonzo Clark, states that once it was freely used in America, but has now been practically abandoned. The Superintendent of the Alfred Hospital, Melbourne, informs me, that as a matter of routine, 5 grains of calomel are given (if there are no signs of exhaustion) on three consecutive evenings until the bowels are well opened. Its use is always attended with good results, in some cases the fever was cut short; any rise of temperature was treated with another dose—ptyalism is rare. Dr. Hare, of Brisbane, writes: 'I once thought that a few large doses of calomel given at the beginning, caused a certain number of cases to abort, but larger experience has taught me it was a case of post, and not propter hoc.' Just as many cases will abort after a dose of castor oil, which I prefer, as it has not the same tendency to cause diarrhoea.

"(2.) As to 'antifebrin,' the experience of Dr. Peirce with this drug at the 'Coast Hospital' has been given. As so much interest has been taken of late in this drug I have collected all the information I could about its action, &c. Introduced by Cahn and Hepp at the end of 1886, they claimed that in doses not exceeding 30 grains daily, it was a certain reducer of temperature without ill effects. The fall of temperature is accompanied by redness of the skin, sweating, and a feeling of cold. During the re-rise there is seldom any shivering, nausea, or diarrhoea, but sometimes cyanosis. At a meeting of the Herveian Society, held February 17th, 1887, Dr. Sidney Phillips stated that though antipyrin was a most valuable antipyretic, and that collapse, due to the drug, was rare unless over large, or over frequent doses were given, yet antifebrin was much superior to antipyrin. Dr. Walter Barr, of Illinois, U.S., says that in continued fevers antifebrin is much to be preferred, as the dose is smaller than that of antipyrin, the antipyretic action stronger, and the depressing effects slighter. Professor Nothnagel, of Vienna, states that profuse sweating and collapse do occur with antifebrin, but not often if properly administered. Other continental observers speak of it as an all-powerful drug, producing frequently alarming and serious symptoms, and especially cyanosis. It is said to be four times stronger than antipyrin, and to cause no cerebral disturbance. A good dose given early in the day has a more potent effect than smaller doses frequently repeated. If the temperature is brought to the normal by a good daily dose (15 to 30 grains) for two or three days, it will be found that small doses (2 to 3 grains) daily will often suffice to keep it low afterwards. It acts as a diuretic and anodyne, slows the pulse, and increases arterial tension. The temperature begins to fall in an hour after a big dose, and then falls for three hours. The re-rise may be higher than the temperature at the beginning of treatment. In the Edinburgh

Royal Infirmary this drug is much used by Dr. Grainger Stewart, and much praised; in Switzerland by Dr. Secretan, Drs. Gortz, and Huber. The latter found the re-rise of temperature very sudden, and rigors and collapse frequent. At the Alfred Hospital, Melbourne, antipyrin and antifebrin have been tried with little success, and the same can be said of Prince Alfred Hospital, Sydney. Dr. Hare, of the 'Brisbane Hospital,' states 'the only advantage of antifebrin is the rapidity of its action, which, however, is very evanescent. It causes much sweating (generally a bad symptom, as it seems to me), collapse, and tends to depress the action of the heart. Opinions as to the value of this drug are, therefore, widely different; in the hands of some it appears to have 'done wonders,' in the hands of others it has ignominiously failed, and has proved, like many other drugs, a double-edged weapon. In this paper I am avoiding as far as possible the commoner remedies known to all, and am confining my attention to recent, or comparatively recent innovations; but time will only permit me to briefly mention such drugs as 'naphthaline,' which has been employed with a view to abort typhoid, sulphide of calcium, oil of eucalyptus, digitalis, caffeine, and strophanthus. M. Landowsky, who believes that the symptoms of typhoid are due to 'ptomaines,' caused by Eberth's bacillus, makes use of carbon, iodoform, salicylate of bismuth, and naphthaline. Good results have been claimed for the antiseptic treatment by iodine, carbolic acid, and by injection of carbolic acid and other disinfectants. Dr. Lauder Brunton thus describes the action of antifebrin or acetanilide: 'It has been introduced as an antipyretic in man, and it has been given in typhoid fever, erysipelas, rheumatic fever, and other febrile conditions. It reduces the temperature rapidly, the effect lasting from three to seven hours, according to the size of the dose. The pulse is slowed, and the patient falls into a quiet sleep. No vomiting or diarrhoea has been noticed, but there is some tendency to collapse. A quarter of a gramme of antifebrin is said to have the same effect as one gramme of antipyrin. It produces a slight burning sensation on the tongue, and is freely soluble in alcohol, wine or ether.'

"Bokai is of opinion that the cyanosis observed in man is caused by vascular spasm.

"Physiological action, nervous system.—Lepine, Dujardin, Beaumetz, Grunneberg, Oharcot, and Weill, agree in the power of antifebrin to diminish the reflex excitability of the spinal cord. It acts especially on the respiratory function, which is markedly slowed. According to Heinemann, deafness and mydriasis have occasionally occurred with therapeutic doses.

"Circulatory system.—It first stimulates the vasomotor constrictor system, leading to increased arterial tension. This is soon followed by dilatation of the cutaneous arterioles, and perspiration. The heart at first is quickened, then slowed and strengthened. Prolonged use of the drug is said to produce fatty degeneration of the heart muscle.

"Temperature.—It reduces normal temperature by influencing both heat production and heat dissipation, and it reduces high fever by decreasing heat productions. It has no influence on the digestive system; the urine is greatly increased in amount. The drug may be removed from the urine. It is an analgesic and hypnotic. It may produce violent sweats, prostration, cyanosis, irregular pulse, collapse and clonic spasms. It is uncertain in its action.

In the *British Medical Journal* for December 31, 1887, there is a review of antipyretics generally. Brand lays stress on the treatment by cold baths simply, without drugs and states the great advantages over Lieber-

meister's treatment by cold baths and large doses of quinine, and over treatment with antipyretic drugs—such as kairin, thallin—antipyrin and antifebrin. By baths the fever is reduced without producing collapse or other bad symptoms. The dry tongue becomes moist, the cerebral symptoms improve, in fact the bath acts as a stimulant as well as an antipyretic. At the Medical Congress held at Wiesbaden, the majority of physicians expressed their opinion that baths influenced the course of typhoid more favourably than the chemical antipyretics, for baths not only act on the symptoms of high temperature but stimulate the nervous system by their action on the cutaneous nerves, by direct reflex excitation of the sensory cutaneous nerves, and their influence on the vasomotor nerves. According to Cayley the mortality of typhoid fever in London has been reduced from 16 per cent, to 10 per cent. by means of the baths, whether cold or graduated. My own experience of the cold bath treatment, both in typhoid and pneumonia, has been most satisfactory. In a hospital where there are many cases of typhoid it is quite impossible to use the cold bath treatment as a matter of routine. At St. Bartholomew's Hospital in London, where the expectant treatment is the favourite, cold baths have been tried, but with little success. The reason, I believe, is that the patients are too far advanced in the disease on admission. There must be great danger in moving patients during the third week, and later, when ulceration of the intestine is at its height. Treatment by the cold bath or cold pack is more often successful in private practice; sponging with lukewarm or cold water is useful in all cases, and ice has been applied over the cardiac region—in the axilla, and over the right iliac region with benefit; Enemata of ice-cold water are praised by some physicians. It is highly advantageous to allow patients with typhoid to drink as much water as they like. At the Alfred Hospital, Melbourne, the cold pack is much used. At the Brisbane Hospital Dr. Hare commenced the cold bath treatment on January 1, 1887, at first rather cautiously, but still every case where it was considered safe was treated systematically, without waiting for bad symptoms or hyperpyemia. Brand's treatment has almost exclusively been carried out (in a few cases large doses of quinine are given in addition to the baths—after the manner of Liebermeister). Stimulants are used freely in bad cases, but no other drugs, except to meet accidents and complications, such as hæmorrhage, diarrhoea, &c. The results of the bathing treatment have been very marked. It is very rare indeed to meet with a case of delirium in the wards, except cases which are admitted delirious, and a day or two's treatment usually suffices to disperse it. Almost all other symptoms are milder, especially the dry tongue and sordes; abdominal symptoms are less affected, though tympanitis and diarrhoea are decidedly lessened when treatment is begun early. Dr. Hare is of opinion that the low mortality of 1887, 11.5 per cent., and of 1888 (first six months) 8 per cent., as compared with 1885, 14.2 per cent., is in a great measure due to the treatment by cold baths. We now come to the important question of stimulants. At the Coast Hospital only two ounces of alcohol are given a day, when there are signs of cardiac failure, &c.—a truly homœopathic dose, as Dr. Smith in his letter referred to remarks. There can be no doubt that a rational use of alcohol is most beneficial, its effects must be watched, and the desired results obtained from the smallest quantity possible. Its use must be regulated by the pulse. Sir W. Jenner states, 'it calls forth the strength, and does not create it.' In the typhoid condition champagne is often invaluable.

Mild cases do not require any alcohol, in some cases it should be reserved till the first sound of the heart is indistinct. Dr. Collie states, 'Alcohol is extremely valuable in the stage of convalescence.' The Superintendent of the Coast Hospital remarks in his Report: 'Chest complications were generally regarded as of secondary importance in comparison with the enteric lesion.' My own experience has convinced me that chest complications account for the deaths of a great majority of typhoid patients, and are therefore of 'primary importance,' and should be treated accordingly. Passing over the treatment of the other common complications such as diarrhoea, tympanitis, peritonitis, perforation, hæmorrhage, we come finally to the consideration of the 'diet,' as there is much difference of opinion on this subject. The usual routine dieting of most hospitals, where so many pints of beef tea and milk are ordered 'per diem,' is not without its disadvantages. It is said that a pint of milk contains as much solid matter as a full-sized mutton chop. It would be better, therefore, to dilute the milk with lime-water or barley-water, or even to pancreatize it—and Mellin's or Benger's food can be added without risk. In some cases arrowroot and custards have been given throughout the fever, and extract of malt is used, and does no harm. Relapses, as a rule, cannot be traced to errors of diet, and Dr. David King, of St. Bartholomew's Hospital, London, has written an excellent paper in the Hospital Reports, showing the fallacy of attributing all relapses to carelessness in the diet. In conclusion, gentlemen, I will draw your attention to the most important points for discussion this evening, and will classify them as follows:—

- "1. The use of antipyretics generally, but especially of the later drugs, *e.g.*, antipyrin and antifebrin.
- "2. The treatment by cold or graduated baths, packs, sponging, &c., &c.
- "3. The antiseptic treatment of typhoid.
- "4. The expectant treatment of typhoid.
- "5. The probable causes of the low mortality at the Coast Hospital, and
- "6. Of the higher mortality in the metropolitan hospitals.
- "7. Stimulants.
- "8. Dieting.
- "9. The treatment of constipation.
- "10. The use of opiates."

Dr. CARRUTHERS then read a paper on the Diagnosis of Typhoid Fever.

Sir ALFRED ROBERTS, whilst congratulating Dr. Jenkins on the condensation of so much information into a small space, would have liked him to have explained more fully the causes of the low mortality at the Coast Hospital for the first half of 1888, as compared with other years.

Dr. FAIRFAX ROSS stated that the statistics for St. Vincent's Hospital for 1887, published by Government authority, giving a mortality of 22 per cent. were incorrect. He believed strongly in the use of stimulants, guided by the pulse. Constipation should be treated by enemata of olive oil, and drugs by the mouth avoided. He had found antifebrin a most valuable drug, and his results at St. Vincent's Hospital, after using it, were excellent. It is a certain antipyretic, and every reduction of temperature is a gain to the patient. He strongly deprecated the use of cold baths.

Dr. KNAGGS quoted from a "Medical Report of the Fever Hospital and House of Recovery, Dublin," showing the advantage of having "observation wards" attached to a "hospital."

Dr. ORAGO gave his statistics of typhoid in his private practice: In 1885, 26.9 per cent.; 1886, 11.4; 1887 and

1888, he had no deaths. He had little experience with antifebrin, but found it caused collapse, but relied mainly on quinine with hydrochloric, or hydrobromic acids. In cases of delirium he used "liq. opii sedativus," five drops every four hours.

Dr. McCULLOCH gave his reasons for the low mortality at the Coast Hospital.

1. The type of fever this year is milder, due to the new water supply.
2. Typhoid patients are received at the Coast Hospital in an early stage of the disease.
3. The climate is most suitable for typhoid.
4. There is an independent water supply and perfect drainage.

He quoted Le Clerc on the action of antifebrin causing great reduction in the red cells, and laid great stress on the immense value of alcohol in the typhoid state.

Dr. MURRAY ORAM agreed with Dr. Jenkins that statistics were most misleading. The mortalities at the various hospitals could not be compared without a careful perusal of the temperature charts, histories, &c., &c. The type of the fever must be known, and the hygienic surroundings. He believed the treatment at the "Coast Hospital" had very little to do with the low mortality there. Routine treatment was of little use. The individual must be treated as well as the fever. The cold bath treatment was most useful. Chemical antipyretics had their value, but he did not lay great stress on them. If he were asked which drug was most valuable he would say "turpentine," and he was a firm believer in alcohol, both as stimulant, antipyretic, and antiseptic.

Dr. MACLAURIN said Dr. Jenkins was quite right in saying selected cases were sent to the Coast Hospital, but similar cases had been sent for the last few years, so that the low mortality for the first five months of the year could not be merely due to this; the advantage now is not greater than previously. Dr. Jenkins seemed to think there may have been errors in diagnosis, this was hardly likely, as each case sent was certified as typhoid by two practitioners, and as a matter of fact he could affirm mistakes were very rarely made. The error in the statistics of St. Vincent's Hospital for 1887 was the fault of the Resident Medical Officer.

Dr. MACLAURIN was a firm believer in antifebrin when judiciously used, and he had found it most useful in those serious cases of typhoid where profuse sweating was combined with high fever. He quite agreed with Dr. Ross as to the dangers of the cold bath treatment and the value of enemata of olive oil, he had not found turpentine very satisfactory. Common sense was an important factor in the treatment of typhoid.

In answer to a question put by Sir A. Roberts, Dr. MacLaurin stated he believed the low mortality at the Coast Hospital for the early part of the year was due to—

1. The devotion of the Medical Superintendent and nurses.
2. The mildness of the type of the disease.
3. The introduction of antifebrin.

In replying, Dr. JENKINS regretted time would not allow him to refer to the remarks of each speaker. In speaking of the Coast Hospital he did not mean to imply that errors in diagnosis were made, he only wished to ascertain whether cases of febricula were included amongst the typhoid cases. Many medical men believe that these cases, occurring during an epidemic of typhoid, are mild forms of that disease. He begged to thank the members for the keen interest taken in the discussion.

Dr. WORRALL exhibited a fibroid tumour of the uterus, with nine distinct outgrowths.

And the meeting then terminated at 11 p.m.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

The ordinary meeting of the Branch was held in the Royal Society's rooms, Sydney, on Friday, 3rd of August, 1888, at 8.15 o'clock. Present—Dr. Chambers (President), in the chair; Drs. Knaggs, Ross, Lloyd, Megginson, Pockley, W. J. O'Reilly, Wm. Chisholm, Warren, Fiaschi, Quaife, Hankins, Shewen, A. T. O'Reilly, Garrett, Fisher, Scot-Skirving, Clubbe, McCulloch, Parker, Thring, Twynam, Crago, West, Worrall, Kendall, Sydney Jones, Breneman. Visitor, Mr. McDonald.

The minutes of the previous meeting were read and confirmed.

The following gentleman was elected a new member—Dr. Todd, of Waverley.

The HON. SECRETARY (Dr. Scot-Skirving) read a letter from Mr. John Elliott, drawing the attention of the members to the destitute condition of Dr. Cummings, of Woollahra.

Resolved that the matter be left in the hands of Dr. W. W. J. O'Reilly.

THE ADMINISTRATION OF ANÆSTHETICS.

Dr. KNAGGS read a paper on the Ethics of the Administration of Anæsthetics (*see page 296*). This paper embodied the writer's own views, and was brought forward as an introduction to a discussion on this important subject.

The PRESIDENT (Dr. Chambers) said Dr. Knaggs deserved the thanks of the members for having brought so interesting a matter as the administration of anæsthetics before the Branch. There were two things which men just fresh from the University always thought they thoroughly understood: 1st, the administration of anæsthetics, and 2nd, the diseases of women. As to the responsibility of the operator and the administrator, he (Dr. Chambers) was not quite sure as to the exact amount of responsibility each should take; but there should, without doubt, be the utmost confidence between them. With regard to the chloroformist being present at the consultation prior to the operation, no doubt it would be advantageous, but he (Dr. Chambers) thought it hardly practicable. It would be a great advantage to have a chloroformist appointed to each of the Sydney Hospitals, not only for the administration of anæsthetics, but also to give instruction to the students, for as far as he (Dr. Chambers) knew, there was little or no instruction in this particular matter given to the students at the present time. Deaths very rarely, if ever, occurred under the hands of an experienced chloroformist.

Dr. SHEWEN said he did not think the responsibility of the administration of anæsthetics should be equally divided between the operator and the administrator, but always fell wholly on the latter once the patient was taken charge of. As to the administrator being present at the preliminary examination, he (Dr. Shewen) did not think it necessary, for there was always time to make a proper examination of the patient before the operation. Nothing could be more annoying to an operator than not to have confidence in the administrator of the anæsthetic. He would like to have a chloroformist appointed at the Prince Alfred Hospital. He (Dr. Shewen) would not like it to be understood that the students at the Alfred did not receive proper instruction in this matter.

Mr. G. T. HANKINS agreed in the main with the remarks of Dr. Shewen, and did not think that there should be an equal responsibility between the operator and the chloroformist. No doubt, in hospital practice,

where the anæsthetic might be given by a student, the operator should take his full share of the risk; but not so in private practice, as the operator would, no doubt, select an administrator in whom he had the utmost confidence, then each should be responsible for his own particular work.

DR. CLUBBE said he had often been appalled at the reckless way in which chloroform had been used. In the paper read by Dr. Knaggs no mention was made of the ethics of the administration of an anæsthetic by one man, single-handed. He (Dr. Clubbe) would like to know what the members thought of this point.

DR. QUAIFFÉ said with regard to the question raised by Dr. Clubbe as to the giving of chloroform by one man, he (Dr. Quaife) had given a great deal of thought to the matter, and had come to the conclusion that in a great city like Sydney, where the services of a second man could be easily obtained, it was always better to call in assistance. Of course, there would always be cases where a man would use a little chloroform by himself. He would not in simple confinements give an anæsthetic, another practitioner not being present. He had often offended patients by refusing to do so.

DR. WORRALL said the operator could not divest himself of a large responsibility in the administration of an anæsthetic. If the operator had not entire confidence in the person who was giving the anæsthetic, how could he feel comfortable when in the midst of his operation. The operator's attention should not be divided; he should not have any thoughts as to how the patient was progressing under the anæsthetic. He (Dr. Worrall) thought the risk of giving chloroform in the cases of midwifery should be undertaken by one man in cases of emergency and where patients' means did not allow of a second fee.

DR. MCGINSON said at Leeds Infirmary the House Surgeon always gave the anæsthetic. He thought that a House Surgeon would personally desire to add to his experience during operations by more variation in his duties than that. At Edinburgh, second and even first year's men gave the anæsthetic. Professor Sir Joseph Lister especially upheld this system. To give students the impression that this duty was very dangerous would be a false course of action, and the impression would be difficult to remove afterwards. Touching civil actions, if a jury was allowed to take against the chloroformist for being young, for instance, there would be no end to further extension of such a view. Suitors against medical men were not of the genus who knew much about ethics; if they did, they set it aside carefully. In dealing with that question it would be forced upon them to make a rule of obtaining written release from legal action previously to operating. This part of the subject and "its ethics" were surely worthy of development at the present day on their own account.

DR. SHAND made a few remarks.

MR. G. E. TWYNAM said with regard to the risk of the administration in the hands of an experienced man, he (Mr. Twynam) thought that Mr. Clover, of London, was a man of very large experience, and yet he (Mr. Clover) had administered to 4,000 patients without a death, and then had two deaths in a fortnight.

DR. SCOT-SKIRVING said, in private practice the primary responsibility should rest equally with the operator and the administrator, and both should be satisfied as to whether or not the patient was fit to be placed under an anæsthetic. After the patient was under the anæsthetic, then he agreed with Dr. Shewen in thinking that the responsibility fell on the administrator. If an accident happened, then the operator's duty was to give the administrator the moral support of his presence at any subsequent enquiry. Dr. Shewen

stated that the students at the Alfred Hospital received proper instruction as to the administration of anæsthetics; this he (Dr. Scot-Skirving) did not think was quite the case. In Edinburgh, all students were allowed to personally administer under proper supervision, and if our students were allowed to feel the personal responsibility of giving chloroform under the supervision of an experienced man, there would ultimately be fewer deaths from anæsthetics.

DR. SYDNEY JONES regretted that he had not been present when Dr. Knaggs opened the discussion, but from what he could gather the principal matter under discussion was, as to the responsibility of the operator and the administrator. Both were responsible to a degree; but the regular medical attendant was the best one to decide as to what anæsthetic should be used; the person called in to administer would not have the same chance as the operator to know what conditions existed. The moment the operation was commenced, the operator could not possibly be expected to have any responsibility as to the administration of the drug. Both then were responsible, but the responsibility differed in time, and in degree. There could be no doubt as to the advisableness of the administrator seeing the patient at the consultation, but this was not always practicable. He (Dr. Jones) was strongly of opinion that chloroform specialists should be appointed to all Metropolitan Hospitals, and that every student should have opportunities of administering chloroform.

DR. KNAGGS, in reply, thanked the members for the manner in which they had received his remarks, as well as for their courteous criticisms. He apologised for appearing to oppose the appointment of specialists to administer anæsthetics in public hospitals, while he really approved of such officials as experts and instructors of students. His apparent antagonism was merely a subterfuge adopted to draw a decided expression of opinion from those speakers who were to follow him. With regard to Dr. Chambers' opinion that deaths from chloroform very rarely occurred under the hands of experienced chloroformists, he wished to state that in six of the cases occurring in Sydney during the past four years, wherein he had made autopsies, it was proved that every reasonable care had been used in the administration of the anæsthetic.

The question as to the respective degree of responsibility incurred by the operator and the administrator of the anæsthetic caused most controversy in this discussion, and no doubt it was a most difficult question upon which to decide. He thought Dr. Sydney Jones had best described the position in saying that it differed in time and in degree. A crucial investigation into the causes of death during operations under anæsthetics, and a decision as to which of the parties concerned in the operation should face the coroner and jury in case of a fatal result, might more critically decide this question. It certainly was within the fitness of things to establish a rule in medical ethics that every person who took an active part in a surgical operation under anæsthetics, which terminated fatally, should attend and give evidence at the judicial inquiry into the cause of death, and thereby give that necessary moral support and assistance to the colleague who gave the anæsthetic. He might relate an instructive instance that happened in his own practice, as a reply to those who thought that the administrator of the anæsthetic was to be held responsible once the patient was under its influence. A scorpion bite caused a malignant ulcer, involving the elbow joint of a lad; amputation seemed the only chance of saving life, but the usual friend of the family interfered and prevented the parents from giving their consent until some weeks later, when it

was palpable to them that death must soon ensue. At their urgent request, when the case was all but hopeless, we operated, and the lad died on the table. Here was a death to which the administrator of the anæsthetic did not in the least contribute. He would relate another instance which was investigated by a coroner's jury: A very trivial operation was attempted in order to relieve the agony of a dying man, with fatal results. Yet it was difficult to decide which contributed most to cause death, the operation or the anæsthetic, at most the final end of the case was but briefly anticipated.

Assuming, therefore, that the respective responsibilities of operator and anæsthetist not only differed in time and in degree, but also varied according to circumstances, he thought that both as essential factors to every operation should be prepared to equally share the responsibility, and while doing so adopt such a code of ethics as would contribute towards the protection of all.

DR. GARRETT announced that he had received £106 towards the Jockel Relief Fund.

SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

MONTHLY Meeting held at the Adelaide Hospital on the evening of Thursday, August 30.

Present, Dr. Stirling (President) in the chair; Drs. Davies-Thomas, Cawley, Gardner, Verco, London, Symons. Messrs. Gault, Lawrence, Giles, Ewbank, Clindening, and the Hon. Sec.

The minutes of the previous meeting were read and confirmed.

Dr. POULTON exhibited a man on whom he had performed Supra-pubic Lithotomy in July.

Dr. DAVIES THOMAS showed the kidneys and pelvic viscera of a man on whom he had recently operated for the extirpation of a large pelvic hydatid, and who had died of surgical kidneys.

Mr. ALFRED SMITH, of Crystal Brook, was elected a member of the British Medical Association and of its South Australian Branch.

Dr. LONDON read some remarks bearing on Dr. Gardner's paper on Supra-pubic Lithotomy. The president and others having discussed the operation, Dr. Gardner replied.

Dr. THOMAS read a paper on "Cholecystotomy" (*vide* p. 303) discussion on which was postponed until the next meeting.

The discussion on Dr. Gardner's paper (p. 275), adjourned from the last meeting, was opened by Dr. London reading a short paper on "Supra-pubic Lithotomy in Young Children" (see p. 306). With regard to Dr. Gardner's cases, comment was made on the fact that Litholapaxy in adults does not appear to have met with that favour in Australia to which its success elsewhere seems to entitle it.

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NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, SEPTEMBER 15, 1888.

EDITORIAL.

WOOD VERSUS CAMPBELL.

IN this case Dr. Ramsden Wood, late of Stanmore, sued Mr. Campbell in the Sydney District Court for £15 8s. 6d. on account of medical attendance on his deceased wife. The defendant pleaded that he was not indebted, and entered a claim by way of cross-action for £200, on the plea that his wife's death arose through negligence and want of skill on the part of the plaintiff. The hearing of the case extended over two days, and the jury gave a verdict for the defendant, awarding him £200 as claimed, on the following grounds, viz.:—

1. That there had not been sufficient examination of the patient before the administration of the chloroform.

2. That Dr. Wood ought not to have left the patient until he saw signs of returning consciousness.

3. That every appliance ought to have been in the room in case of emergency.

Being in possession of the whole of the evidence in the case, and having in addition carefully perused the depositions taken at the inquest on the body, we cannot but express our belief that the verdict is a miscarriage of justice, and that the finding of the jury is not justified by the facts. We think not only is it one calculated to unjustly reflect on the profession of medicine, but that it is likely to do infinite harm to the public, and be the cause of increased suffering to many unfortunate invalids, who will be made to suffer from the natural reluctance of medical men to accept the unnecessarily increased moral and pecuniary responsibility which has by the result of this trial been cast upon them.

It appears that, on October 17, 1887, a consultation was held on Mrs. Campbell at her own

house by Drs. Wood and Foreman, who decided that pus was present in the pelvic tissues, and that its evacuation was essential to her recovery. That the patient might receive every attention and care, she was removed to Dr. Wood's private hospital, and on October 22 was brought under the influence of chloroform by that gentleman, when the necessary operation, occupying less than seven minutes, was performed by Dr. Foreman. The patient was replaced in bed, constantly watched by a trained nurse and by Dr. Wood until she had partially regained consciousness, the latter only then leaving her to speak with Dr. Foreman for a very short period, about 30 seconds, still retaining, however, a full view of the patient. Evidence was given that there were attempts at vomiting,—in itself a sign of returning consciousness; but suddenly collapse set in, and, though in our opinion every essential means was taken to avoid it, death ensued.

Dr. Knaggs, who made the *post-mortem* examination, and heard all the evidence adduced at the inquest, stated, in his evidence at the inquest, that he found a pale, flabby heart, which exhibited signs of "extensive fatty infiltration," all the valves, however, being healthy. "He was of opinion that death took place subsequent to the administration of chloroform, in consequence of the depressing action of chloroform upon the heart enfeebled by fatty infiltration; that due and sufficient care was exercised in the administration of the chloroform; and that, when serious symptoms arose, prompt and proper measures were adopted to restore animation." He also said, "I may add that it is not always possible to ascertain this condition of the heart by the most careful examination;" and in this we thoroughly agree with him.

The verdict of the coroner's jury, who had all the evidence before them when the matter was fresh in the memories of the witnesses, absolutely exonerated Dr. Wood, and we prefer to accept the decision of twelve men given on recent facts to that of four on a trial nearly a year later, with the issue confused by extraneous evidence of men having no personal knowledge of the case, accompanied by all the sophistries of paid advocacy.

The effect of verdicts such as this will be to put the use of anæsthetics beyond the reach of the poorer classes, except in such cases as are treated in a hospital, for no man possessed of the average amount of prudential caution will dare to take the responsibility of administering chloroform or ether alone, whilst it may be out of the power of the friends of the unfortunate patient to pay the second fee necessary to obtain the attendance of another medical man to protect the reputation

of the first in the event of death occurring from some unavoidable cause.

The absence of Dr. Wood from the colony at the time of the trial is much to be regretted, for his evidence, taken *de bene esse*, was necessarily ineffective, and would have been much strengthened by cross-examination. This absence, however, we are informed was unavoidable, so there is nothing more to be said on it.

THE VICTORIAN POST OFFICE AND ADVERTISING QUACKS.

THE utter disregard shown by the Government of New South Wales to matters relating to the protection of the public from fraud and deception by the numerous quacks making their residence in that colony, but advertising in the newspapers of the others, is remarkable. It is, perhaps, most easily explained by the fact that Sir Henry Parkes is the Premier, and that he thinks the guarding of the people in such a sublimary matter is much too trifling to be worthy of consideration by a man of his exalted genius. The revelations made through the late Select Committee would have been sufficient to have moved any ordinary man in his position to effective action, and its urgent necessity was pressed upon him twelve months since by a letter from a number of most representative men, including the Lieutenant-Governor, and the Chief Justice of New South Wales, the Primate, and the Cardinal. The motive cause of the foregoing dissertation is the praiseworthy action of the Postmaster-General of Victoria in refusing to allow the post office of that colony to be made use of as an agent in the nefarious proceedings of advertising quacks. His decision that all letters addressed to them shall be opened and returned to the writers will be most effective in neutralising the evil likely to result from their scheming. Some of the circulars sent by these men to members of respectable families are simply disgusting, and a Government fails in its duty which does not exercise all the power which it possesses to prevent the continuation of such glaring abuses.

Notwithstanding the exposures made during 1887, and the evidence given by a clerk in the post office that there were fourteen letter boxes in the Sydney General Post Office made use of by quacks for the purposes of their business, nothing has been done, and the Postmaster-General continues to allow his department to be made a portion of a system of fraud on the credulous and ignorant, which is not only astounding, but unequalled in any other country in the world.

LETTERS TO THE EDITOR.

CASE OF POISONING BY HYDRO-BROMATE OF HYOSCINE.

(To the Editor of the A. M. Gazette.)

SIR,—The following case may, perhaps, be of interest to the profession. A lady had been under my care for ill-defined pelvic pains, disproportionate to the discoverable physical signs, and I thought I should try the new drug, hydrobromate of hyoscine, lately recommended for such cases by Skene, of New York, and others. I therefore gave one of Parke, Davis & Co.'s $\frac{1}{100}$ of a grain tabloids hypodermically while the patient was on my examining couch. In about ten minutes she said she felt faint, and asked for a drink; then she complained of difficulty in swallowing, dryness of the throat, and a "terrible feeling." The pupils became gradually widely dilated, and the pulse weak and rapid, until, finally, it could scarcely be felt. The skin was cold and clammy, and altogether her condition seemed desperate. I gave 25 min. of ether hypodermically, and repeated the dose in 15 minutes. I also gave four hypodermics of pilocarpin, gr. $\frac{1}{10}$, at intervals of 20 minutes, without producing the usual physiological effects of this drug, mustard to the cardiac region, enema of black coffee, and sips of brandy and water. All these measures combined, gradually effected an improvement, but she could not be sent home for 10 hours, and caused me a world of trouble and anxiety. When next I administer this drug it will be in one quarter of the dose recommended in the text books.—I am, Sir, yours, &c.,

RALPH WORRALL.

20 College Street, Sydney, August 18, 1888.

DRUMINE.

(To the Editor of the A. M. Gazette.)

SIR,—The following case of positive-negative evidence is interesting in the estimation of subjective phenomena. A lady suffering from a herpetic (lumbar) eruption, very painful, red, and tender at one spot, bore the tender part touched with evidence of great pain. When it was painted over with solution of drumine, at first she winced; other parts were then painted over. On being asked if it was easier, she replied that there was no difference, it felt stiff. When the tender part was touched, she did not know; although she maintained it was still painful, much to her sister's amusement (evidence of tenderness having disappeared being so apparent). To mention other cases would be to travel over old ground.

It is my present intention (if I have the permission of the authorities), to give a rough history of drumine, to exhibit articles occurring in the manufacture, as well as drumine itself, and to point out the difficulties which have occurred in my own hands, and the methods

adopted in overcoming them, at the Intercolonial Congress in Melbourne. Great credit is due to the pluck of Dr. Schuchardt, Görlitz, Germany, who now supplies drumine at 20s. per gramme, and to Messrs. Parke, Davis, and Co., Detroit, U.S.A., in their attempting to manufacture (I trust with success) the product in question. They are in possession of facts not yet published, but intended for the Medical Congress.

My thanks are due to those of the profession who have lent me their sympathy and their patience. To those who have been kind enough to attribute to me a monomania on drumine, I would say that their fears on that score are likely to be dispelled in a few months.

JOHN REID, M.A., M.D.

Melbourne, Aug. 29, 1888.

MEDICAL ETIQUETTE.

(To the Editor of the A. M. Gazette.)

SIR,—“A.” and “B.” are two medical practitioners residing in a small country township. “A.” has practised there about five years, “B.” about two. “B.” has to visit Melbourne on business, and is away four days without previously making any arrangement with “A.” about his patients. During his (“B.’s”) absence, a lady whom he had attended during the whole of his residence in the district is taken seriously ill, and, “B.” being away, “A.” is sent for. “A.” before “B.’s” arrival in the district had always attended the family. “A.” makes two visits; but, on the evening of the day on which he makes his second visit, “B.” returns by coach. While passing the patient’s residence, the coach is stopped by a messenger on the look out for “B.” who requests “B.” to see the case immediately, as there appeared to be imminent danger. “B.” complies with the request, and then hears that “A.” is in attendance. The case, however, in the opinion of the family being serious, “B.” does what is necessary, and then informs the patient and her friends that he will not call again, “A.” being already in charge of the case; to which they all demur, saying that “A.” was only called in in consequence of “B.’s” absence, and that as “B.” was their regular medical attendant they wished him to look after the case as usual. “B.” then requests the husband to write to “A.” a courteous note, which he immediately does, the same being forwarded to “A.” the next morning (the earliest opportunity) together with a note from “B.” explaining the circumstances. It may be added that the patient resides about nine miles from the township.

“A.” considers himself aggrieved by “B.’s” action, and asserts that he, “B.” has acted unprofessionally, and without any regard to the rules of medical ethics, therefore your opinion upon it will oblige—Yours, &c.,

VICTORIAN.

[UNDER the circumstances as reported by “Victorian,” we are of opinion that “B.” acted with due consideration towards “A.” in this case and that the latter has no reasonable cause for dissatisfaction.—Ed. A. M. G.]

A CORRECTION.

(To the Editor of the A. M. Gazette.)

SIR,—I regret to find that in your report of my paper on Nephro-Lithotomy, the incision described and spelt by me as Langenbuch’s has appeared in your issue of August 15 as Langenbeck’s.

Kindly correct this in your next number, and oblige.

WM. GARDINER.

Victoria-square, Adelaide, August 18, 1888.

THE INSANE POPULATION OF QUEENSLAND IN 1887.

THE annual report of the Medical Superintendent of the Asylums for the Insane in Queensland for the year 1887, which has just been issued, shows that the number of patients which remained in the asylums at Woogaroo and Ipswich on 31st December, 1886, was 811; 504 males and 307 females. The number admitted during the year 1887 was 234—154 males and 80 females; of these 142 males and 71 females were admitted for the first time, while 12 males and 9 females had previously been under treatment in the asylums. The total number under care during the year was 1,045—658 males and 387 females. The number of patients discharged was 115, of these 63 females and 46 males had recovered; and 6, 4 males and 2 females, were relieved. The number of deaths was 55—36 males and 19 females. One patient absconded and was not recaptured. The total number of patients removed from the asylums by death, discharge, &c., was 171—104 males and 67 females; these, taken from the number admitted, give an increase of patients during the year of 63—50 males and 13 females. The number remaining under care on 31st December, 1887, was 874—554 males and 320 females, all of whom (except 119 males, who are at Ipswich) reside at Woogaroo. The average number daily resident was 836—524 males and 312 females. Regarding the admissions Dr. Scholes calls special attention to the following points:—1. The large number who have been insane and in asylums in Great Britain and whose attacks have recurred within short periods after their arrival in Queensland. Sixteen persons are known to have been insane before leaving home, and these form over 6 per cent. of the admissions during the year. 2. The large number of persons who arrive by immigrant ships and are admitted to the asylum, some direct from the ships, others after comparatively short residences in the colony. Twenty-nine persons, many of whom are ascertained to have insane family histories, were admitted during 1887 under the above-mentioned circumstances; these give an additional 12 per cent. of imported lunatics admitted during the year. Of the total patients (234) admitted during 1887, 21 had been at some previous time in this asylum. The number of recoveries—109—gives a percentage on the admissions of 46.5. The number of deaths—55—is smaller than last year, although the average number daily resident this year exceeds that of last year by nearly 50. The percentage of deaths on the average number daily resident is 6.58. Four of these deaths only occurred at Ipswich Asylum. Of these deaths 23 were caused by diseases of brain and nervous system, and 10 by consumption. Twenty-six persons—9 males and 17 females—were allowed leave of absence from the asylum for periods varying from one to six months. Of these 12 were discharged recovered, 7 were returned to the asylum at the expiration of their leave, and 7 remained still on leave at the end of the year. The gross cost for maintenance of the asylums, Woogaroo and Ipswich, for 1887 was £24,079 16s. 4d.; or the sum of £28 6s. 1d. per head per annum, or a weekly cost of 11s. 1d. per patient. The amount obtained for sale of asylum produce (pigs, tallow, &c.) was £194 4s. 3d. The amount collected and paid into the Treasury by the Curator in Insanity was £2,179 19s. 7d.; these sums deducted from the gross cost gives a net cost per head per year of £25 19s. 3½d., or 9s. 11½d. per week per patient.

BURROUGHS & WELLCOME'S EXHIBITS AT THE CENTENNIAL INTERNATIONAL EXHIBITION, MELBOURNE.

AMONGST the hundreds and thousands of exhibitors at the Melbourne Exhibition, there is scarcely a trade or business but what is represented in some form or another. As the saying goes, "Anything, from a cradle to a coffin," can be found there.

Physic is represented strongly, as also are surgical instruments, hospital bandages, &c., &c.

Amongst the representative pharmacists will be found Messrs. Burroughs, Wellcome & Co., whose preparations are so well known that we do not consider a detailed description of them necessary. Their exhibit is made up in two beautiful cases, which stand in the main avenue, and immediately alongside the British Commissioner's office. One of the show-cases is a perfect work of art. It is magnificently carved, and made out of Indian teak wood, which formed an interesting feature of the Colonial and Indian Exhibition.

Pharmacy has made rapid strides during the last decade, and we think few firms have done more towards its progress than the firm in question. The difficulty to be met with in introducing a new medicine or a new form of drug is very apparent to all who have had any experience in this direction. However, Messrs. Burroughs, Wellcome & Co. seem to have overcome it, and to some purpose, for it does not matter what quarter of the world we may travel, we always see and hear of their preparations. We can only say that our experience of their goods has been such as to compel us to wish them every success in their business, for the improvements which have reached us have been most neat and valuable.

One of the latest developments is the pinus pumilio, an extract from the shoot of the pumilio pine. It is used in baths and as a liniment in gout, neuralgia, &c.

Saccharin in tabloids are now prepared, and so arranged that one or two tabloids equalize the same number of lumps of sugar.

An improvement in the manufacture of the Kepler Extract of Malt and the combination of malt c. oil is maintained. These preparations, however, must have enjoyed a very large sale under the old form of production.

Hazeline and beef and iron wine, as also a great variety of compressed tabloids, for which the firm is famous, are on view in the Exhibition.

The display of their preparations, interspersed with hypodermic syringes in cases, medicine-chests, buggy-cases, &c., make a very handsome and creditable exhibit.

Medical Books at PUBLISHED Prices.

MR. BRUCK, Medical Bookseller in Sydney, begs to inform the profession that he is selling all medical books at PUBLISHED prices. An assortment of the latest works has just been received by the R.M.S. "Oceana." A list of some of the books in stock, with published prices attached, can be had on application.

MARTINDALE and WESTCOTT'S EXTRA PHARMACOPEIA, 5th edition, 1888, price 7s 6d; postage 3d. About the end of October Mr Bruck will receive 100 copies of the new edition of this useful book of reference, orders for which are now being received, and will be executed on arrival of the book.—L. BRUCK, Medical Bookseller, Sydney.

THE MONTH.

NEW SOUTH WALES.

At a recent meeting of the Senate of the University of Sydney it was resolved that in future the Faculty of Medicine shall be composed of the Chancellor, Vice-Chancellor, Fellows of the Senate who are legally qualified members of the medical profession, the Professors and Lecturers in the subjects of the medical curriculum, and the Examiners in Medicine appointed by the Senate.

THE first of the session of sectional meetings of the members of the Australasian Association for the Advancement of Science was held in the lecture-room at the Sydney University, on August 29. In Section H—*Sanitary Science and Hygiene*—Dr. Bancroft, of Brisbane, delivered the Presidential Address, in which he referred to the various hygienic aspects of Australian life. Papers were also read on "The Classification of Persons who have been exposed to the Infection of Small-pox, so as to show the relations between Incidence of the Disease upon them, and their Different Degrees of Protection by Vaccination or by Former Attack," by Dr. J. Ashburton Thompson; and "the Study of Theatre Hygiene," by W. E. Roth, B.A.

DURING the seven months ended July 31st, 466 people were treated in five Sydney and suburban hospitals for typhoid fever, of which 58 terminated fatally. The cases per 10,000 of the population treated show the following returns:—Sydney, 8.90; north-western district, 11.44; west-central, 23.64; east-central, 14.52; eastern, 26.12; western and southern, 6.86, North Shore, 10.46. Average, 13.02.

In the Sydney District Court, on August 28 and 29, Dr. Ramsden Wood, late of Stanmore, but now residing in England, brought an action against a Mr. Campbell to recover £15 8s 6d for medical services rendered to defendant's wife. The defendant pleaded never indebted, and, by way of cross-action, claimed £200 damages on the ground of Dr. Wood's incompetence and negligence, which, he pleaded, caused the death of his wife. The damages mentioned, however, were only claimed formally, Mr. Campbell merely wishing the jury to affirm by their verdict the incompetence and neglect of Dr. Wood. The deceased lady had died under chloroform while under the doctor's care, and evidence was given to show that the drug had been improperly administered, and that sufficient care was not taken while she was under its influence. The jury found a verdict accordingly, and the Judge granted costs against Dr. Wood on the higher scale.

DR. F. A. POCKLEY, of North Shore, has been appointed Lecturer on Ophthalmic Medicine and Surgery at the University of Sydney.

TENDERS have been accepted for the erection of a new hospital at Broken Hill, at a cost of £3,566.

At a meeting of subscribers of the Gundagai Hospital, held on August 28, Dr. C. L. Gabriel was elected Medical Officer of the institution; there were four candidates for the position.

At a meeting of the subscribers to the Walgett Hospital, held on August 13, Dr. R. P. Rankin was appointed Medical Officer by a majority of one vote.

WE very much regret to have to announce the death of Dr. George Marshall, M.D. Glas., 1849, L.R.C.P., Edin., 1850, one of the oldest practitioners in Sydney, who died at his residence, No. 2 Lyons-terrace, Hyde

Park, on September 1. The deceased gentleman arrived in the colony thirty years ago, and for some years practised at Wollongong. He afterwards removed to Sydney where he carried on one of the most lucrative practices; at the time of his death he was a member of the New South Wales Board of Health, Honorary Consulting Medical Officer of the Sydney Hospital, and Consulting Medical Adviser to the New South Wales Education Department.

DR. W. B. CLAY, of Rockdale, has been appointed, temporarily, Health Officer for the city of Sydney, in the place of Dr. Dansey, dismissed. There were five applicants for the office.

DR. ARMITAGE FORBES, late of the Tweed River, has succeeded to the practice of Dr. A. A. Cohen, at Grafton.

DR. JAMES GRAHAM, Medical Superintendent of the Prince Alfred Hospital, Sydney, has received from the University of Edinburgh, the degree of Doctor of Medicine, with a gold medal, for a thesis on the subject of "Hydatid Disease and its Treatment."

ON August 31, Dr. James Graham, who for the last few years has occupied the position of Medical Superintendent of the Prince Alfred Hospital, Sydney, was presented with a handsome gold English chronograph watch, suitably inscribed, together with a group photograph of the members of the general staff, to mark the occasion of his retirement from a post which he has long and ably filled. Dr. J. F. M'Allister, his successor, made the presentation, and in so doing referred at some length to the esteem in which Dr. Graham was held by those who, in the discharge of their duties, had come in contact with him.

DR. A. W. HAWTHORNE, late of Winton (Qu.), has commenced practice at 6 Moore Park road, Paddington, Sydney.

DR. T. R. HORTON, late of Emmaville, has removed to Grenfell, where he has been elected Medical Officer of the local hospital.

DR. D. L. KELLY has commenced practice at "Clyde House," 117 Beattie street, Balmain, a suburb of Sydney.

DR. R. READ, of Singleton, has been appointed a member of the Licensing Court for the district of Patrick's Plains.

DR. HARMAN J. TARRANT, of Sydney, has been appointed by his Excellency Lord Carrington, the Grand Master, Pro-Grand Master of the United Grand Lodge of New South Wales.

ON September 5, a coroner's inquest was held in Sydney on the body of a man who had died suddenly from an overdose of cocaine, hypodermically administered.

NEW ZEALAND.

THE University of Otago has been recognised by the Royal College of Surgeons and Physicians in Edinburgh as fulfilling the requirements of the board in regard to professional study for diplomas of the two colleges.

DR. JAMES CAMPBELL, M.D. et Ch. M. McGill Univ., Montreal, 1871, committed suicide at Warkworth, Prov. Auckland, on September 7, by taking chloroform. He left a certificate of his death with his man-servant, with a letter stating that he should like his head sent to Professor Halford, of the Melbourne University. The deceased gentleman came to the colony in 1882, and practised first at Brunnerton (Westland) and for the last few years at Warkworth. Formerly, he held the

appointment of Medical Officer to the State Hospital in San Francisco, the Hospital in Singapore, and Jardine's Hospital in Hong Kong.

DR. A. A. COTTEW has been deprived of his commission as Honorary Surgeon to the Riversdale Rifle Volunteers, for absence from the colony without leave.

THE HON. DR. M. S. GRACE, M.L.C., of Wellington, has been accredited by the Government as a representative of New Zealand at the Paris Exhibition.

DR. A. F. WRIGHT, late of Te Aroha, has succeeded to the practice of the late Dr. Thorpe, at Westport, in a coal-mining district, 145 miles S.W. of Nelson.

QUEENSLAND.

THE new hospital at Thargomindah was opened on August 10 with a grand ball and supper. The new building is a substantial brick structure capable of accommodating fifteen patients, and was erected at a cost of about £2,000; it is without doubt one of the prettiest and most commodious institutions of the kind anywhere in Western Queensland.

DR. J. BANCROFT, of Brisbane, has resigned his position as representative of Queensland on the Intercolonial Rabbit Commission.

DR. T. W. FRANCIS has settled at Bundaberg, and Dr. C. S. Sutton, a graduate of the Melbourne University, at Muttaburra.

DR. D. W. B. WILKIE, late of Auckland (N.Z.), and formerly of Winchelsea (Vic.) has settled at Springure, 485 miles N.W. of Brisbane; Dr. Wilkie has been appointed Surgeon of the local hospital.

A PERSON named G. W. Gibson, formerly of Sydney, but now practising as a medical herbalist in Brisbane, who has been some time on remand charged with having administered a noxious drug to a young woman for the purpose of procuring abortion, was on August 30 committed for trial at the next sittings of the Criminal Court.

SOUTH AUSTRALIA.

ON the recommendation of the Faculty of Medicine, Dr. B. Poulton has been appointed Lecturer on Clinical Surgery at the University of Adelaide for the remainder of the current year, in the place of Dr. Görger, resigned.

IN the Adelaide Police Court on August 22, eight people were charged with neglecting to have their children vaccinated within six months of birth. The defendants nearly all stated that they were strongly opposed to their children being operated upon, owing to the ill results which might ensue. One defendant was so strong in his opposition to the operation that he stated that sooner than have his child vaccinated he would take him out of the colony. One of his children, he asserted, had contracted a skin disease through vaccination. Several other cases of serious consequences after the operation were cited, and one defendant alleged that the operation had been the direct cause of a child's death. All the defendants were fined 10s. and fees 10s. These convictions are the first under the Act.

DR. J. H. EVANS, late Resident Medical Officer at the Melbourne Hospital, has been appointed Junior Resident Medical Officer at the Adelaide Hospital.

DR. J. H. S. FINNISS, of Glenelg, has been elected Honorary Medical Officer of the South Australian Blind, Deaf and Dumb Institution, in the place of the late Dr. Dunlop; the other candidates were Drs. Morrison and F. W. Ellison.

DR. S. J. MAGAREY, of Adelaide, M.D. of the Melbourne University, has been admitted to the same degree *ad eundem gradum* in the University of Adelaide.

VICTORIA.

ON Saturday evening, August 11, Mr. T. N. Fitzgerald, F.R.C.S.I., President of the next Intercolonial Medical Congress, entertained at dinner the organising committee, secretaries of sections, and other officials of the Congress. During the evening a letter was read from the Hon. Dr. Mackellar, of Sydney, resigning his position as president of the section of medicine, and, in his place, the Hon. Dr. W. F. Taylor, of Brisbane, was elected.

CORRESPONDENCE has passed between the Medical Board and the Chief Secretary of Victoria upon the advisability of the Government taking measures to have medical diplomas issued by the Melbourne University recognised in Great Britain. A difficulty has arisen in the matter in consequence of the provisions of the Victorian Medical Act prohibiting the Medical Board from registering a foreigner as a legally qualified medical practitioner until he has become a naturalised British subject. Imperial legislation makes no such distinction, and the English Government decline to register as practitioners the holders of diplomas from the Melbourne University, unless the local law is brought into accord with that of Great Britain. At the request of the University and the Medical Board, the Attorney-General has consented to introduce a bill to make the desired amendment of the Medical Act.

A SUB-CENTRE of St. John Ambulance Association has been formed at Warrnambool; Dr. R. Vandeleur Kelly and Dr. Fleetwood were appointed Lecturers at a meeting held on August 18.

DR. B. J. ADAM, late of the Royal Infirmary, Glasgow, has commenced practice at Beaufort, in an agricultural, pastoral and mining district, 129 miles N.W. of Melbourne.

DR. G. CUSCADEN, late of Urana (N.S.W.), has commenced practice at Port Melbourne.

DR. T. TAYLOR DOWNIE, late Clinical Assistant at the Glasgow Eye Infirmary and Glasgow Hospital for Diseases of the Ear, has commenced practice at 266 Queen's parade, Clifton hill, near Melbourne, in conjunction with Dr. Stock, of North Fitzroy.

DR. W. H. DUTTON, late of Malvern, and formerly of Castlemaine, has succeeded to the practice of Dr. A. V. Henderson, at Lilydale, in a vine-growing district, 25 miles E. of Melbourne.

DR. J. CARNEGIE MACMULLEN, late Honorary Physician at the Auckland Provisional Hospital, has commenced practice at 127 Collins street East, Melbourne, and also at High street, St. Kilda, a fashionable suburb of Melbourne.

MR. ALEXANDER MURRAY, M.B. Melbourne, 1887, who for ten years practised at Prahran, near Melbourne, died on August 13, at the early age of 34 years.

DR. A. W. F. NOYES, jun., who has been assisting his father, Dr. Noyes, sen., at Deniliquin (N.S.W.), for the last fifteen months, has joined Dr. Snowball in his practice at Carlton (Melbourne).

DR. J. OLIVER, late of Boort, has commenced practice at Rose Hill, Glen Eira road, Caulfield, a suburb of Melbourne.

DR. SHIRLEY ROBERTS has removed from Avoca to Romsey, 39 miles north of Melbourne.

DR. R. YOUL, of Melbourne, has been appointed an Inspector of Anatomy for Victoria.

PROCEEDINGS OF COLONIAL MEDICAL
BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective boards:—

NEW SOUTH WALES.

Nelly, John Francis, L.R.C.P. Edin., 1887; L.R.C.S. Edin., 1887; L.F.P.S. Glas., 1887.
Smith, Robert, L.R.C.S. Edin., 1882; L.A.H. Dub., 1880.
Watson, Walter Carter, M.D., Bellevue Med. Coll., New York, U.S.A., 1888.
Schlusinger, Karl, M.D., Univ. Freiburg, 1887; State Examination Certif., Carlsruhe, 1887.

NEW ZEALAND.

Gault, David, L. & L. Mid. R.C.S. & R.O.P. Edin., 1880.

QUEENSLAND.

Sutton, Charles Stanford, M.B. Melb., 1887.
Banoroff, Peter, M.B. & Ch. M. Syd., 1888.
Harding, Thomas Massey, M. 1848, F. 1868, R.O.S. Eng.; L.S.A. Lond., 1849.
Francis, Thomas William.

Provisional registration:—

Fetherstonhaugh, William, M.B. Dubl., 1866; L.R.C.S. Irel., 1867.

SOUTH AUSTRALIA.

Macmillan, Alexander Ronald, M.B. & Ch.M. Edin., 1885; L. Mid. Edin., 1885.

TASMANIA.

Smith, Robert, L.R.C.P. & R.C.S. Edin., 1869; F.R.C.S. Ed., 1873.

VICTORIA.

Wisewould, Percy, M.B. & Ch. M. Edin., 1887.
Hamilton, Alfred James, L.R.C.P. & R.C.S. Edin., 1887; L.F.P.S. Glas., 1887.
Langdon, John Arthur, L.R.C.P. Edin., 1874; L.F.P.S. Glas., 1874.
Abbott, Thomas Eastoe, L.S.A. Lond., 1880.
McGinness, John, L.R.C.S. Irel. 1884; L. & L. Mid. K.Q.C.P. Irel., 1884.
Adam, Basil John, M.B. & Ch. M. Glas., 1886.
Kennedy, John Timothy, L. & L. Mid. R.C.P. & R.C.S. Edin., 1888; L.F.P.S. Glas., 1888.

Additional qualifications registered:—

Mollison, Crawford H., M.R.C.S. Eng., 1886.
Henry, Louis, M.D. Melb., 1888 (*s.e.g.*).

WESTERN AUSTRALIA.

White, Arthur Thomas, L. & L. Mid. R.C.P. & R.C.S. Edin., 1884; L.A.H. Dubl., 1886.

MEDICAL APPOINTMENTS.

Bennett, Frank Albert, M.R.O.S.E., L.R.C.P. Lond., to be Government Medical Officer and Vaccinator for the district of Morpeth, N.S.W.
Degner, Charles Henry, M.D., to be Public Vaccinator at Myrtleford, Vic.
Dutton, William Henry, M.B. & Ch.M. Edin., M.R.C.S. Eng., to be Public Vaccinator at Lilydale, Vic.
Howitt, Godfrey, M.B. & Ch.B. Melb., appointed Resident Medical Officer at the Melbourne Hospital.
Macdonald, Boderick, M.B. & Ch.M. Glas., to be Government Medical Officer and Vaccinator for the district of Tweed River, N.S.W.
Macmillan, Alexander Ronald, M.B. & Ch.M. Ed., to be a Public Vaccinator in South Australia.
Roberts, Shirley, M.R.O.S.E., L.K.Q.C.P. Irel., to be Public Vaccinator at Bonney and Lancofield, Vic., vice Dr. G. F. Wickens, resigned.
Tennant, Edward Glover, M.R.O.S.E., to be a Vaccinator for the district of Forbes, N.S.W.
Wickens, George Frederick, M.B. & Ch. M. Glas., to be Public Vaccinator at Learmonth, Vic.
Woinarski, Gustave Henry Stephen Zichy, M.B. & Ch.B. Melb., to be Public Vaccinator at West Melbourne, vice Dr. W. H. Cutts, jun., resigned.
Wright, Alfred Figg, L.R.C.P. Ed., L.F.P.S. Glas., to be a Public Vaccinator for the district of Buller, N.Z.

BIRTHS, MARRIAGES, AND DEATHS.

. The charge for inserting announcements of Births, Marriages, and Deaths is 2s 6d, which should be forwarded in stamps with the announcement.

BIRTHS.

DIXSON.—August 23, at Sydney, the wife of Thomas Dixon, M.B., C.M., of a daughter.
O'BRIEN.—On the 16th August, at Carlton (Melbourne), the wife of Dr. J. W. O'Brien, F.R.C.S.I., of a daughter.
SEELENMEYER.—On the 4th August, at Melbourne, the wife of A. F. Seelenmeyer, M.D., of a son.
STIRLING.—On the 28th July, at North Adelaide, the wife of R. C. Stirling, M.D., of a daughter.
TWNAM.—August 8, 1888, at Darlinghurst, Sydney, the wife of G. E. Twynam, M.R.C.S., Eng., of a son.
WOODFORD.—On the 17th August, at Penshurst, Victoria, the wife of Sydney Bidout Woodford, M.B., C.M., of a son.

MARRIAGES.

BOOTH-SKYRING.—On the 23rd August, at Gympie, Queensland, by the Rev. J. W. Henry, James Booth, L.R.C.P., L.R.C.S. Edin., L.F.P.S. Glas., to Amy Geneva Rose, third daughter of Zachariah Skyring, Mumbanna, near Gympie.
HUXTABLE-WALSH.—On the 15th August, at Brisbane, by the Ven. Archdeacon Dawes, Louis Ralston Huxtable, M.B., of Sydney, to Lillie, eldest daughter of the late Hon. William Henry Walsh, Brisbane.
MACGILLICUDDY-MEANNEY.—On the 18th July, at Melbourne, by the Rev. M. P. Carroll, Dr. D. Florance MacGillicuddy, to Marianne, eldest daughter of Daniel R. Meaney, of Clifton-hill, Victoria.
SCOTT-MICKLE.—On the 31st July, at St. Kilda, Melbourne, by the Rev. E. J. Iok, Henry James Herbert Scott, M.R.C.S., of Cordillera, N.S.W., to Mary Minnie, youngest daughter of the late Thomas Mickle, Warrnambool, Victoria.

DEATHS.

CROSSEN.—On the 12th August, at St. Kilda, Melbourne, Isabella, wife of Dr. H. Crossen, surgeon.
HORNE.—On the 16th August, at Mount Prior, Gooramadda, Victoria, Jessie, wife of George Horne, M.A., M.B., C.B., aged 31 years.

PUBLICATIONS RECEIVED.

The Principles of Cancer and Tumour formation. By W. Roger Williams, Surgical Registrar to the Middlesex Hospital. London: John Bale, 1888.
A Practical Text Book of the Diseases of Women. By Arthur H. N. Lewers, M.D. Lond., M.R.C.P. Lond., Assistant Obstetric Physician to the London Hospital, with illustrations. London: H. K. Lewis, 1888.
Anæsthetics, their uses and administration. By Dudley Wilmet Buxton, M.D., B.S., &c. London: H. K. Lewis, 1888.
The Treatment of Hæmorrhoids, by injections of Carbolic Acid and other substances. By Silas T. Yount, M.D. 2nd edition. Lafayette, Ind.: 1888.
A Compend of the Practice of Medicine. By D. E. Hughes, M.D. Philadelphia: P. Blakiston, 1887.
Intracranial Tumours. By Byron Bramwell, M.D., F.R.C.P.E., F.R.C.S.E., illustrated. Edinburgh: Young J. Pentland, 1888.
The Abortive Treatment of Specific Febrile Disorders by the Binioidide of Mercury. By C. R. Illingworth, M.D. (Ed.), M.R.C.S. London: H. K. Lewis, 1888.
The Extra Pharmacopœia. By Wm. Martindale, F.C.S., and W. Wynn Westcott, 5th ed. London: H. K. Lewis, 1888.
On the Action of Snake Poison and the Use of Strychnine as an Antidote. By Augustus Müller, M.D., of Yackandandah (Vic.). Melbourne, 1888.

REPORTED MORTALITY FOR THE MONTH OF JULY, 1888.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Cancer.	Child-bearing.
N. S. WALES.														
Sydney	132,846	846	169	58	1	3	4	...	2	3	1	13	6	2
Suburbs	215,849	881	295	135	8	3	30	...	7	6	27	11	14	9
NEW ZEALAND.														
Auckland	35,639	82	25	8	...	1	2	...	1	...	1	2	...	...
Christchurch...	16,217	21	14	4	...	...	1	...	...	1	3	3	5	...
Dunedin	24,334	46	20	7	...	...	...	...	1	...	1	1	...	1
Wellington	28,235	90	44	14	...	...	1	...	1	...	4	3	1	1
QUEENSLAND.														
Brisbane	51,689	198	82	34	}	...	14	1	2	8	9	4	...	...
Suburbs	21,960	115	28	15										
SOUTH AUSTRALIA	309,916	932	313	99	...	...	18	1	6	...	37	22	11	5
Adelaide	43,527	97	70	14	...	...	2	...	1	...	13	1	1	1
TASMANIA.														
Hobart	32,028	92	61	17	...	1	1	...	1	1	2	7	3	3
Launceston	20,105	61	34	6	...	1	2	...	1	...	...	6	2	1
Country Districts.....	92,653	265	59	...	...	...	3	...	1	...	...	...	...	...
VICTORIA.														
Melbourne	69,774	158	84	190	...	...	27	...	12	5	89	46	19	10
Suburbs	275,606	1,074	510											

METEOROLOGICAL OBSERVATIONS FOR JULY, 1888.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.			Depth.	Days.		
							Inches			
Adelaide—Lat. 34° 55' 33" S. ; Long. 138° 36' E. ....	...	62.3	52.5	39.7	29.965	...	...	...	...	...
Auckland—Lat. 36° 50' 1" S. ; Long. 174° 49' 2" E.	115.	61.5	51.8	40.	...	3.850	20	79	...	...
Brisbane—Lat. 27° 28' 3" S. ; Long. 153° 16' 15" E.	128.8	75.8	58.5	39.5	30.112	0.047	5	59	s.	...
Christchurch—Lat. 43° 32' 16" S. ; Long. 172° 38' 59" E.	116.6	61.8	42.8	26.8	...	2.323	13	78	...	...
Dunedin—Lat. 45° 52' 11" S. ; Long. 170° 31' 11" E.	95.	60.	40.8	30.	...	13.946	13	84	...	...
Hobart—Lat. 42° 53' 32" S. ; Long. 147° 22' 20" E. ....	...	60.5	45.	29.2	29.815	1.66	15	85	...	...
Launceston—Lat. 41° 30' S. ; Long. 147° 14' E. ....	...	57.2	45.2	26.	29.909	2.87	17	90	...	...
Melbourne—Lat. 37° 49' 54" S. ; Long. 144° 58' 42" E. ....	...	64.2	48.4	28.3	29.942	1.51	15	...	...	...
Sydney—Lat. 33° 51' 41" S. ; Long. 151° 11' 49" E.	67.8	53.3	39.3	30.067	2.61	6	70	w.	...
Wellington—Lat. 41° 16' 25" S. ; Long. 174° 47' 25" E.	105.	59.	48.1	35.	...	4.437	21	82

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